

Annual Physical Examination [ ]

Pre-Employment [ ]

Last Name RUGAN First Name FAUSTIEN FAEZ M.I. A. Date 07-01-19  
 Address BANILAD, CEBU CITY Age 25 Civil Status SINGLE Sex F  
 Place of Birth ILIGAN CITY Date of Birth 04/13/1994 Insurance Provider \_\_\_\_\_  
 Occupation CSR Name of Company 1play Tel. / Mobile no. 09494489706

**PHYSICAL EXAMINATION**

Temp.: 36.8 °C PR: 69 bpm RR: 14 bpm BP: 100/80 mmHg Ht: 154 cm Wt: 48 kgs.  
 Visual Acuity: Right Eye: 20/30 Left Eye: 20/30 BMI: 20.2 Underweight:  Overweight:   
 (With/Without eyeglasses) Normal Weight:  Obese:

**MEDICAL HISTORY**

Past Medical History: CH2-38A/ly x 5/yr, arid ang p/ner C-15/1A  
 Family History: \_\_\_\_\_  
 Previous Hospitalization: CT 1005 - AP  
 Menstrual History: 12 y.o Parity: 60P0 LMP: 6/3/19 Contraceptive Use: none  
Regular, 3-5 days

Review of Systems	Normal	Findings	Review of Systems	Normal	Findings
Head & Scalp	/		Lungs	/	
Eyes & Ears	/		Heart	/	
Skin / Allergy	/	<u>CH2-38A/ly</u>	Abdomen	/	
Nose & Sinuses	/		Genitals	/	
Mouth / Teeth / Tongue	/		Extremities	/	
Neck / Nodes	/		Reflexes	/	
Chest/ Breast	/		BPE	/	

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	/		ECG	/	
CBC	/		Other Procedures:	/	
Urinalysis	/			/	
Fecalalysis	/			/	
Drug Test	/			/	

I certify that I have examined and found the employee to be physically [ ] Fit [ ] Unfit for employment.

Classification:

CLASS A Physically fit for all types of work

CLASS B Physically fit for all types of work  
 Has minor ailment/ defect. Easily curable or offers no handicap to job applied.  
 Needs treatment/ correction  
 Treatment optional for: \_\_\_\_\_

CLASS C Physically fit for less strenuous type of work. Has minor ailments/ defects.  
 Easily curable or offers no handicap to job applied.  
 Needs treatment/ correction  
 No treatment needed for: \_\_\_\_\_

CLASS D Employment at the risk and discretion of the management

CLASS E Unfit for employment

PENDING For further evaluation of: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_  
 Patient's Signature Date Examined Medical Examiner, M.D.  
 License No.: \_\_\_\_\_



# Medgrupe Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

2nd Level, APM Centrale, A. Soriano Jr. Ave., N.R.A.  
Mabolo, Cebu City, 6000 Philippines  
Tel Nos. (032) 232-2273 \* (032) 266-3245

## LABORATORY DEPARTMENT

License TO OPERATE No. : 07-065-17-AS-2

No.: 168224 SO No.: 00759755  
 Name: RUGAY, FAUSTIEN FAEZ APAO Age: 25 yrs. Date: 7/ 1/2019  
 Requested by: \_\_\_\_\_ Sex: FEMALE  
 Patient Status: \_\_\_\_\_ Company: IPLOY INC.,  
 Charge To: IPLOY INC.,

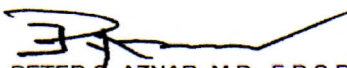
## COMPLETE BLOOD COUNT

			Normal Values
( ) WBC	<u>6,500</u> /mm <sup>3</sup>		5,000-10,000 /mm <sup>3</sup>
( ) RBC	<u>4.73</u> x 10 <sup>6</sup> /mm <sup>3</sup>		<b>Adult</b> F: 4.2 - 5.4 X 10 <sup>6</sup> /mm <sup>3</sup> M: 4.7 - 6.10 X 10 <sup>6</sup> /mm <sup>3</sup> <b>Pedia</b> F: 4.0 - 5.1 X 10 <sup>6</sup> /mm <sup>3</sup> M: 4.0 - 5.3 x 10 <sup>6</sup> /mm <sup>3</sup>
( ) Hemoglobin	<u>14.20</u> gm%		F: 12-15gm% M: 14-17gm%
( ) Hematocrit	<u>42.60</u> gm%		F: 38-48vol% M: 40-50vol%
<b>Differential Count</b>			
Neutrophils	<u>55</u> %		45-65%
Lymphocytes	<u>38</u> %	*	20-35%
Monocytes	<u>5</u> %		2-9%
Eosinophils	<u>2</u> %		0-6%
Basophils	_____ %	--	0-2%
Platelet Count	<u>280,000</u> /mm <sup>3</sup>		150,000-450,000 /mm <sup>3</sup>
Others	_____		

HBsAg \_\_\_\_\_  
 Anti-HAV IgM \_\_\_\_\_

NOTE: \_\_\_\_\_

  
 FLORA MAE B. GALAY, RMT-PRC#85817  
 Medical Technologist

  
 PETER S. AZNAR, M.D., F.P.S.P.  
 Pathologist  
 PRC #72410



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Tel Nos. (032) 232-2273 \* (032) 266-3245

## LABORATORY DEPARTMENT

License TO OPERATE No. : 07-065-17-AS-2

No.: 165791

SO No.: 00759755

Name : RUGAY, FAUSTIEN FAEZ APAO

Age : 25 yrs.

Date: 7/ 1/2019

Physician :

Sex : FEMALE

Company : IPLOY INC.,

Patient Status:

Charge To: IPLOY INC.,

## URINALYSIS

### MACROSCOPIC:

Color	<u>Light Yellow</u>
Appearance	<u>Clear</u>
pH	<u>6.0</u>
Specific Gravity	<u>1.005</u>
Glucose	<u>Negative</u>
Protein	<u>Negative</u>

### MICROSCOPIC:

RBC / hpf	<u>0-1</u>
WBC / hpf	<u>1-3</u>
Epith. Cells / hpf	<u>Few</u>
Casts	<u></u>
Mucus Threads	<u>Few</u>
Bacteria	<u>Rare</u>
Crystals	<u></u>
Amorphous (Urates)	<u>Rare</u>
Amorphous (PO <sub>4</sub> )	<u></u>


### MISCELLANEOUS:

Pregnancy Test	<u>N/A</u>
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### OTHERS:

### NOTE:

  
ELISHA MARIE G. BANA-AY, RMT  
Medical Technologist

  
PETER S. AZNAR, M.D., F.P.S.P.  
Pathologist  
PRC #72410



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DEPARTMENT OF HEALTH  
MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.  
2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU

Phone Number 266 3245

**DRUG TEST REPORT**

CCF No: 201907010008  
Name: RUGAY, FAUSTIEN FAEZ APAO  
Birthdate: 04/13/1994 Age: 25 Gender: F

Transaction Date Time: 7/1/2019 2:15:00PM  
Report Date Time: 7/2/2019 7:23:38AM

Test Method TEST KIT

Purpose  
Private Employment

Requesting Parties  
IPLOY

**Result**

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

Approved By

45 MS. AIMEN JOY GRONIFILLO AGURO

DR. PETER SANSON AZNAR

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Analyst

Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

**PRIME CARE CEBU**



Prime CARE  
C E B U

**MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.**  
2<sup>ND</sup> Floor, APM Centrale Mall, Soriano Ave., NRA, Brgy. Mabolo, Cebu City, Philippines 6000  
Tel. No. (032) 232-2273 Fax: (032) 234-2273  
**CUSTODY AND CONTROL FORM**  
(Form DT-002A - COPY FOR THE DONOR)

SPECIMEN ID NO. 6719

LAB ACCESSION NO. 07010004

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

✓ A. Client's/Donor's/Subject's Name	✓ B. Address: <u>Agala Business Park</u>	✓ C. Age: <u>25</u>	✓ D. Sex: <u>F</u>
✓ E. Employer Name and Address: <u>Iploy, cebu Business Park</u>			
F. Type of Specimen: <input checked="" type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Others(specify) _____	G. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Return to Duty <input type="checkbox"/> Mandatory <input type="checkbox"/> Post Accident <input type="checkbox"/> Follow-up <input type="checkbox"/> Others (specify) _____		
H. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & MET Only <input type="checkbox"/> Others (specify) _____			

STEP 2 COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 32°C and 38°C? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Collection: Specimen Sampling: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split Specimen Volume: <u>6</u> ml.     Physical Appearance: Color: _____	Other Observation (Enter Remark)
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REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initial seal(s). Donor completes STEP 5.  
STEP 4: CHAIN OF CUSTODY – INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Step 5 of this form was collected, sealed and released to the Delivery Service noted in accordance with applicable Department of Health requirements.

X _____ Signature of Collector <u>FRANZ ERIC GARGO</u> (PRINT) Collector's Name (first, MI, Last)	_____ AM/PM Time of Collection <u>JUL 01 2019</u> Date (Mo/Day/Yr)	SPECIMEN BOTTLE(S) RELEASED TO: _____ Name of Delivery Service Transferring Specimen to Lab.
X _____ Signature of Accessioner <u>FRANZ ERIC GARGO</u> (PRINT) Accessioner's Name (First, MI, Last)	_____ AM/PM Time of Collection <u>JUL 01 2019</u> Date (Mo/Day/Yr)	STATUS OF THE SPECIMEN (a) Seal Intact <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (b) Transport Device _____ (c) Description _____
		SPECIMEN BOTTLE(S) RELEASED TO: _____ Signature & Printed Name of Receiving Person Print Name (First, MI, Last)     Date (Mo/Day/Yr)

STEP 5 COMPLETED BY THE DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the affixed bottle is correct.

✓ FRANZ ERIC GARGO  
Signature of Donor  
Contact No. 09424489706

✓ FRANZ ERIC GARGO  
(PRINT) Donor's Name (First, MI, Last)

✓ 07/01/19  
Date (Mo/Day/Yr)  
Date of Birth 04/13/94  
Mo Day Yr

Additional information may be asked from you by the laboratory particularly on drugs and medications.

STEP 6: COMPLETED BY HEAD OF SCREENING LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification is:

NEGATIVE      POSITIVE      TEST CANCELLED      REFUSAL TO TEST BECAUSE:  
 DILUTED      ADULTERATED      SUBSTITUTED  
 OTHERS (Specify) \_\_\_\_\_

REMARKS: \_\_\_\_\_

X AIMEN JOY G. AGURO, RMT  
Signature & Name of Analyst (First, MI, Last)

PETER S. AZNAR, M.D., F.P.S.P.  
Signature & Name of Head of Laboratory (First, MI, Last)

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date (Mo/Day/Yr)

STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

CONFIRMED FOR:  CHALLENGE      FAILED TO CONFIRM – REASON \_\_\_\_\_  
 THC      MET      OTHERS \_\_\_\_\_

X \_\_\_\_\_  
Signature of Analyst

\_\_\_\_\_ (PRINT) Signature & Name of Head of Laboratory (First, MI, Last)

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date (Mo/Day/Yr)

STEP 8: TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL)

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

RECONFIRMED FOR:  FAILED TO CONFIRM – REASON \_\_\_\_\_  
 THC      MET      OTHERS \_\_\_\_\_

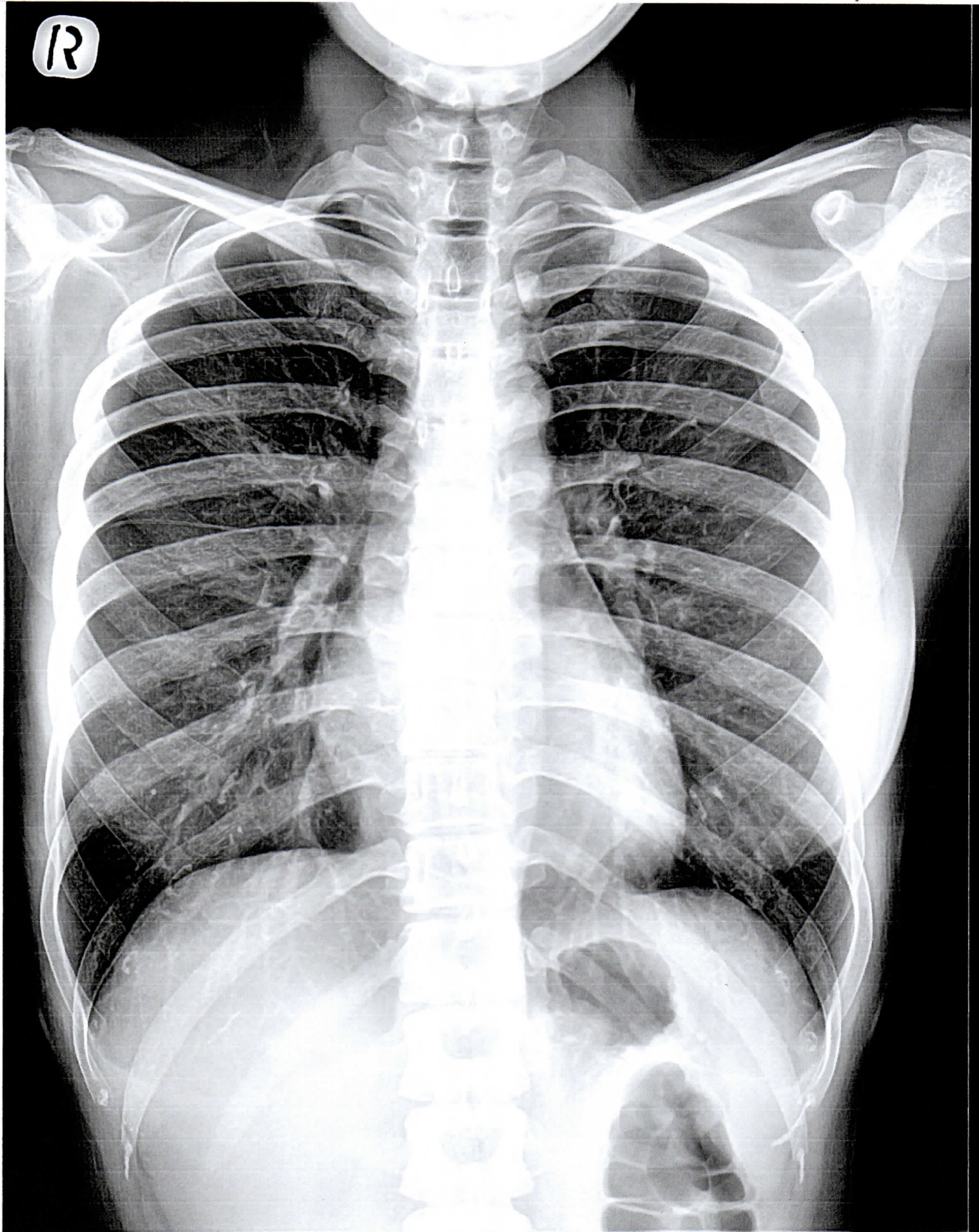
X \_\_\_\_\_  
Signature of Analyst

\_\_\_\_\_ (PRINT) Signature & Name of Head of Laboratory (First, MI, Last)

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date (Mo/Day/Yr)

1. Form DT – 002A - Copy for the Donor
2. Form DT – 002B - Copy for the Collection Site
3. Form DT – 002C - Copy for the Laboratory
4. Form DT – 002D - Copy for the Confirmatory Laboratory (For Positive Sample)

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Patient ID: 19-11580 IPLOY INC  
Patient Name: RUGAY,FAUSTIEN FAEZ  
Study Date: 07/01/2019