Prime Care CEB
IMMEDIATE MEDICAL & DENTAL CARE CENTER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [ ] Pre-Employment [✓]

Last Name VILLASIS **First Name** RUEL **M.I.** S. **Date** 7-4-19

Address TUNGKIL, MANDAUE CITY, CEBU **Age** 30 **Civil Status** SINGLE **Sex** M

Place of Birth ZAMBOANGA DEL SUR **Date of Birth** 1-26-1989 **Insurance Provider**

Occupation CSR **Name of Company** iPlay Inc. **Tel. / Mobile no.** 09299741268

PHYSICAL EXAMINATION

Temp.: 35.7 °C PR: 74 bpm RR: 16 bpm BP: 120/60 mmHg Ht: 161 cm Wt: 61.4 kgs.

Visual Acuity: Right Eye: 20/20 -1 Left Eye: 20/20 BMI: 23.7 Underweight: [ ] Overweight: [ ]

(With/ Without eyeglasses) Normal Weight: [✓] Obese: [ ]

MEDICAL HISTORY

Past Medical History: (-) SMOKER 20 STICKS/DAY
Family History: (-) OCCASIONAL ALCOHOLIC DRINKER 2L/BI-MONTHLY (BEER)
Previous Hospitalization: 1994 UTI, 2016 PEPTIC ULCER
Menstrual History: N/A y.o Parity: LMP: Contraceptive Use:

Review of Systems	Normal	Findings	Review of Systems	Normal	Findings
Head & Scalp	✓		Lungs	✓	
Eyes & Ears	✓		Heart	✓	
Skin / Allergy	✓		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	✓				
Fecalysis					
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:

AMPARO T. FLORIDA, MD
License No. 33180

Patient's Signature 7-4-19 / Date Examined , M.D.
Medical Examiner
License No.:

Medgruppe 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.: 168417 SO No.: 00760266

Name: VILLASIS, RUEL SIBUYAN Age: 30 yrs. Date: 7/ 4/2019

Requested by: Sex: MALE

Patient Status: Company: IPLOY INC.,

Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

				Normal Values
( ) WBC	10,400	/mm^3	*	5,000-10,000 /mm^3
( ) RBC	5.23	x 10^6 /mm^3		**Adult** F: 4.2 - 5.4 X 10^6/ mm^3 M: 4.7 - 6.10 X 10^6/ mm^3 **Pedia** F: 4.0 - 5.1 X 10^6/ mm^3 M: 4.0 - 5.3 x 10^6/mm^3
( ) Hemoglobin	15.70	gm%		F: 12-15gm% M: 14-17gm%
( ) Hematocrit	47.10	gm%		F: 38-48vol% M: 40-50vol%
Differential Count				
Neutrophils	54	%		45-65%
Lymphocytes	38	%	*	20-35%
Monocytes	5	%		2-9%
Eosinophils	3	%		0-6%
Basophils		%	--	0-2%
Platelet Count	325,000	/mm^3		150,000-450,000 /mm^3
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.: 165976 SO No.: 00760266

Name : VILLASIS, RUEL SIBUYAN Age : 30 yrs. Date: 7/ 4/2019

Physician : Sex : MALE

Company : IPLOY INC., Patient Status:

Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Yellow
Appearance	Clear
pH	6.0
Specific Gravity	1.020
Glucose	Negative
Protein	Negative

MICROSCOPIC:

RBC / hpf	0-1
WBC / hpf	0-2
Epith. Cells / hpf	Rare
Casts	
Mucus Threads	Rare
Bacteria	Rare
Crystals	
Amorphous (Urates)	Rare
Amorphous (PO_4)	

MISCELLANEOUS:

Pregnancy Test	N/A

OTHERS:

NOTE:

ELISHA MARIE G. BANA-AY, RMT
Medical Technologist

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

IJ

Report ID: DTO-R03

DEPARTMENT OF HEALTH
MEDGRUP OLYCLINICS AND DIAGNOSTIC CENTER, INC.
2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU
Phone Number 266 3245

DRUG TEST REPORT

RH902689
73

CCF No: 201907040036
Name: VILLASIS, RUEL SIBUYAN
Birthdate: 01/26/1989 Age: 30 Gender: M

Transaction Date Time: 7/5/2019 7:25:00AM
Report Date Time: 7/5/2019 9:44:17AM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

Drug/Metabolite	*Result*	*Remarks*
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

78 MS. AIMEN JOY GRONIFILLO AGURO
Analyst

Approved By

DR. PETER SANSON AZNAR **47**
Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

PRIME CARE CEBU

Prime CARE

MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER,INC.

2ND 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. 6859 LAB ACCESSION NO. 07040036

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name ______ √ B. Address: ______ √ C. Age: 30 √ D. Sex: M
√ E. Employer Name and Address iPlay Inc., Ayala Business Park, Cebu City
F. Type of Specimen:
/✓/ Urine
/ / Blood
/ / Others(specify) ______

G. Reason for Test :
/✓/ Pre-employment / / Random / / Reasonable Suspicion/Cause
/ / Return to Duty / / Mandatory / / Post Accident
/ / Follow-up / / Others (specify) ______

H. Drug Tests to be Performed: / / THC, COC, PCP, OPI, AMP /✓/ THC & MET Only / / Others (specify) ______

STEP 2 COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 32°C and 38°C?
/✓/ Yes / / No

Specimen Collection: /✓/ Observed / / Unobserved
Specimen Sampling : /✓/ Single / / Split
Specimen Volume: (60) ml. Physical Appearance: Color: Y

Other Observation (Enter Remark)

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
______ AM/PM Time of Collection
SPECIMEN BOTTLE(S) RELEASED TO:

[stamp] ALYN FLORES
(PRINT) Collector's Name (first, MI, Last)
JUL 04 2019
Date (Mo/Day/Yr)
______ Name of Delivery Service Transferring Specimen to Lab.

RECEIVED AT LAB:
X______ Signature of Accessioner
[stamp] ALYN FLORES
(PRINT) Accessioner's Name (First, MI, Last)
JUL 04 2019
Date (Mo/Day/Yr)

STATUS OF THE SPECIMEN
(a) Seal Intact / / Yes / / 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.

√ ______ Signature of Donor
√ RUEL S. VILLASIS (PRINT) Donor's Name (First, MI, Last)
√ 7 / 4 / 19 Date (Mo/Day/Yr)
√ Contact No. 09299741268
√ Date of Birth 1 / 24 / 1989 (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)

JUL 04 2019
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)

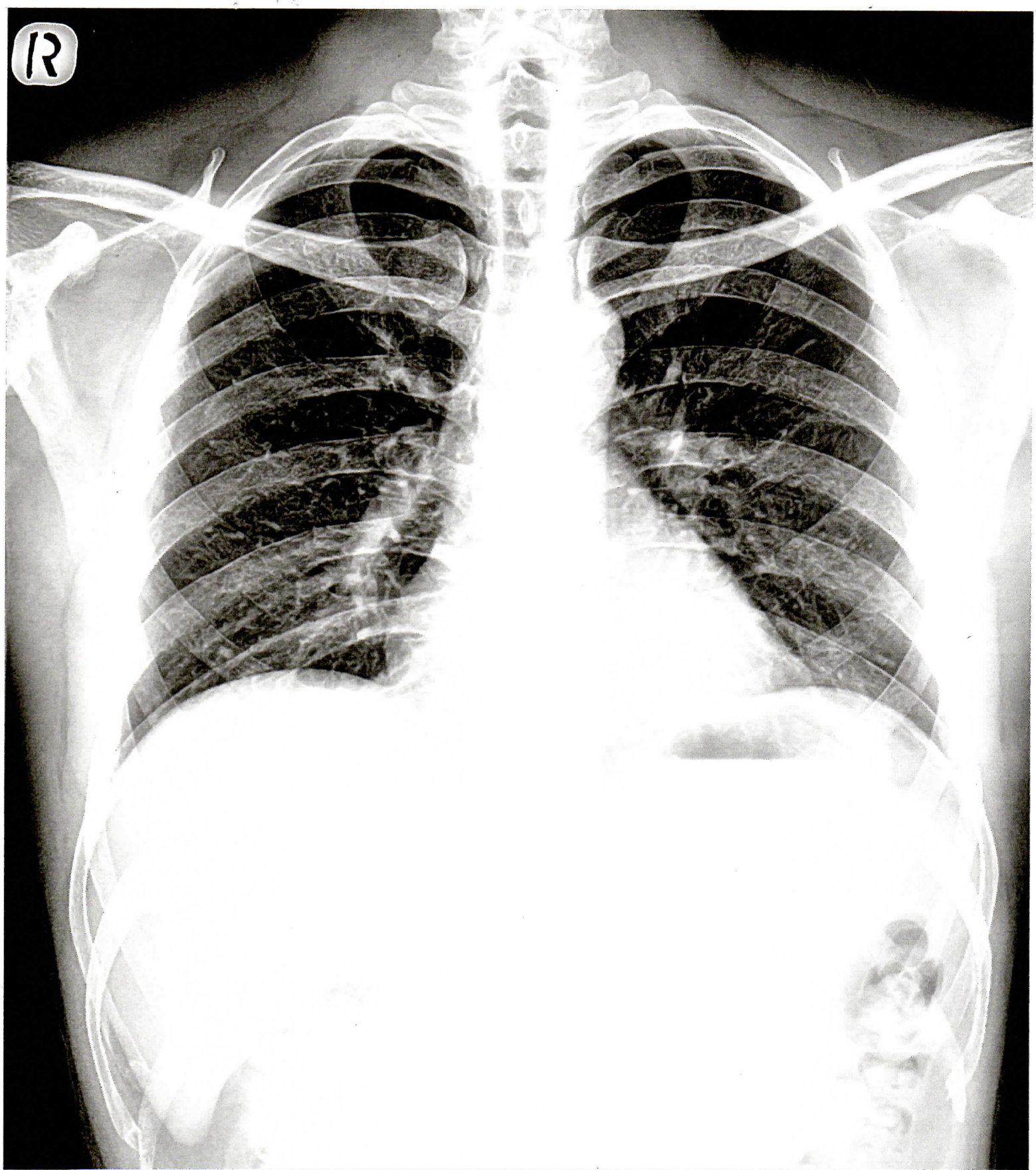
STEP 8 : *TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL*

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

/ / RECONFIRMED FOR: / / THC / / MET / / FAILED TO CONFIRM – REASON ______
/ / 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 (Positive Sample)



Patient ID: 19-11774 IPLOY
Patient Name: VILLASIS,RUEL
Study Date: 07/04/2019