

Annual Physical Examination []

Pre-Employment [✓]

Last Name Dano First Name Jonah Marie M.I. C. Date 07/13/2019
 Address Mactan Newtown, LLC Age 24 Civil Status single Sex Female
 Place of Birth Loboc, Bohol Date of Birth 01/30/1995 Insurance Provider _____
 Occupation BPO - CR Name of Company iPLOY staffing Tel. / Mobile no. 09295076691

PHYSICAL EXAMINATION

Temp.: 36 °C PR: 79 bpm RR: 16 bpm BP: 100/60 mmHg Ht: 145 cm Wt: 57 kgs.
 Visual Acuity: Right Eye: 20/20 Left Eye: 20/20 BMI: 24.2 Underweight: Overweight:
 (With/ Without eyeglasses) Normal Weight: Obese:

MEDICAL HISTORY

Past Medical History: GIHPN GIADMC, Anthony Jr, RFA skimp, G small, Giala drink E, PTB
 Family History: HPN (mother)
 Previous Hospitalization: Dengue fever 2016
 Menstrual History: 16 y.o Parity: G0P0 LMP: 6-14 Contraceptive Use: none

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

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	/		ECG	NA	
CBC	/		Other Procedures:		
Urinalysis	/				
Fecalalysis	NA				
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 Dental caries
 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: _____

[Signature] Patient's Signature _____ Date Examined [Signature] Medical Examiner, M.D.
 License No.: 12013



Medgrupp Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

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

No.: 166511

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

SO No.: 00761414

Name: DANO, JONAH MARIE CALACAR

Age: 24 yrs.

Date: 7/13/2019

Physician:

Patient Status:

Sex: FEMALE

Company: IPLOY INC.,

Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Light Yellow
Appearance	Clear
pH	6.0
Specific Gravity	1.005
Glucose	Negative
Protein	Negative

MICROSCOPIC:

RBC / hpf	0-1
WBC / hpf	0-2
Epith. Cells / hpf	Few
Casts	
Mucus Threads	Rare
Bacteria	Rare
Crystals	
Amorphous (Urates)	Rare
Amorphous (PO ₄)	
MISCELLANEOUS:	
Pregnancy Test	N/A

OTHERS:

NOTE:

ELISHA MARIE G. BANYAAY, RMT
Medical Technologist

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



Medgrupp Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

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

No.: 168945

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

SO No.: 00761414

Name: DANO, JONAH MARIE CALACAR

Age: 24 yrs.

Date: 7/13/2019

Requested by:

Patient Status:

Sex: FEMALE

Company: IPLOY INC.,

Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

() WBC	6,400	/mm ³	5,000-10,000 /mm ³
() RBC	4.26	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	12.80	gm%	F: 12-15gm% M: 14-17gm%
() Hematocrit	38.40	gm%	F: 38-48vol% M: 40-50vol%

Differential Count

Neutrophils	67	%	45-65%
Lymphocytes	26	%	20-35%
Monocytes	4	%	2-9%
Eosinophils	3	%	0-6%
Basophils		%	0-2%
Platelet Count	239,000	/mm ³	150,000-450,000 /mm ³
Others			

HBSAg
Anti-HAV IGM

NOTE:

RAIZA JEYD D. DELA CUESTA, RMT PRQ#
Medical Technologist

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



QL903095
30

DEPARTMENT OF HEALTH
MEDGROUP POLYCLINICS AND DIAGNOSTIC CENTER, INC.
2L APM CENTRALE VIALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU
Phone Number 266 3245

DRUG TEST REPORT

CCF No: 201907130027
Name: DANO, JONAH MARIE CALACAR
Birthdate: 01/30/1995 Age: 24 Gender: F

Transaction Date Time: 7/18/2019 7:50:00AM
Report Date Time: 7/19/2019 7:21:04AM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY STAFFING SOLUTIONS

Result

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

74 MS. AIMEN JOY GRONIFILLO AGURO

Analyst

Approved By

DR. PETER SANSON AZNAR

17

Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

PRIME CARE CEBU



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. 7283

LAB ACCESSION NO. 0713027

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name <u>JONAH MARIE DANO</u>	√ B. Address: <u>MACTAN NEWTOWN, M.C.</u>	Age: <u>29</u>	√ D. Sex: <u>F</u>
√ E. Employer Name and Address: <u>PLDY WITH TRNG VOLUNTEER</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"/> Return to Duty <input type="checkbox"/> Random <input type="checkbox"/> Mandatory <input type="checkbox"/> Follow-up <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Others (specify) _____			
H. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input checked="" 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: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved Specimen Sampling: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split Specimen Volume: <u>10</u> ml. Physical Appearance: Color: <u>Y</u>	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 <u>ANALYN FLORES</u> (PRINT) Collector's Name (first, MI, Last)	Time of Collection <u>JUL 13 2019</u> AM/PM Date (Mo/Day/Yr)	SPECIMEN BOTTLE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab.
---	---	---

RECEIVED AT LAB: X _____ Signature of Accessioner <u>ANALYN FLORES</u> (PRINT) Accessioner's Name (First, MI, Last)	Date (Mo/Day/Yr) <u>JUL 13 2019</u>	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.

Signature of Donor <u>JONAH MARIE DANO</u> (PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr) <u>JUL 13 2019</u>	√ Date of Birth <u>07/30/1991</u> 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:

<input checked="" type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> TEST CANCELLED	<input type="checkbox"/> REFUSAL TO TEST BECAUSE: <input type="checkbox"/> DILUTED <input type="checkbox"/> ADULTERATED <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> OTHERS (Specify) _____
REMARKS <u>Free</u>	Signature & Name of Head of Laboratory (First, MI, Last) <u>PETER S. AZNAR, M.D., F.P.S.P.</u> Date (Mo/Day/Yr) <u>JUL 13 2019</u>
X _____ Signature & Name of Analyst (First, MI, Last) <u>AIMEN JOY G. AGURO, RMT</u>	

STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

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

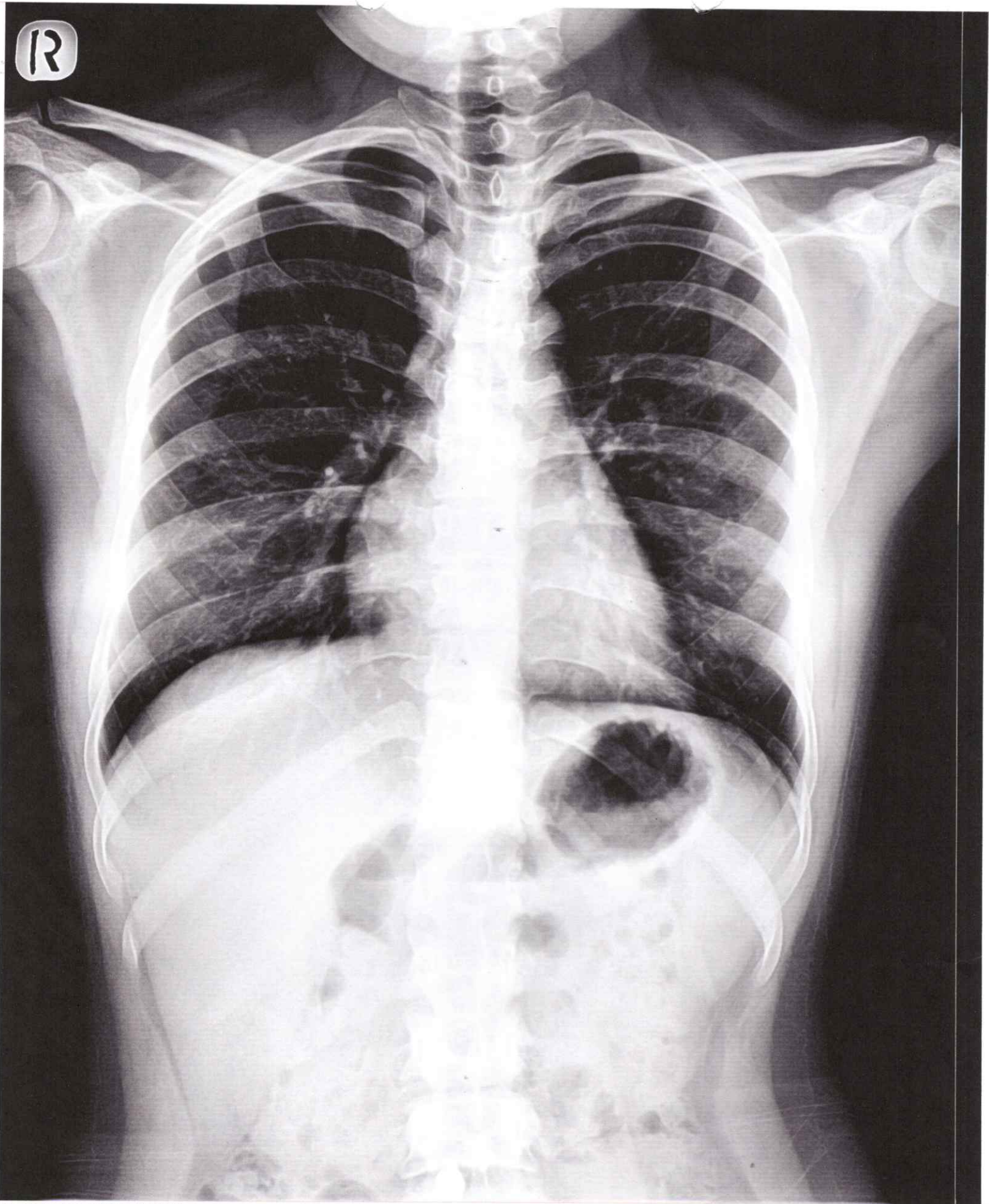
<input checked="" type="checkbox"/> CONFIRMED FOR: <input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> OTHERS _____	<input type="checkbox"/> CHALLENGE <input type="checkbox"/> FAILED TO CONFIRM - REASON _____
X _____ Signature of Analyst	(PRINT) Signature & Name of Head 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:

<input type="checkbox"/> RECONFIRMED FOR: <input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> OTHERS _____	<input type="checkbox"/> FAILED TO CONFIRM - REASON _____
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)



Patient ID: 19-12272 IPLOY
Patient Name: DANO, JONAH MARIE
Study Date: 07/13/2019

MEDGRUPPE POLYCLINICS & DIAGNOSTIC CENTER, INC.

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

SERVICE ORDER

Patient Name: **DANO, JONAH MARIE CALACAR**
 HMO No.: _____ Gender **F** Age **24 yrs.old**
 Address: **MACTAN LLC**
 Result: **For Delivery** Referred by: **IPLOY INC.,**

SO No.: **0000761414**
 Date: **7/13/2019**
 Ref. No.: **761414**
 Date of Birth: **01/30/95**

QTY.	ITEM NO.	DESCRIPTION	DISCOUNT	UNIT PRICE	AMOUNT
1	3811	U, 12/17/19 PA, CBS, UA, DRUG TEST	0.00	650.00	650.00

NOTE. PLS. COMPLY ALL THE TESTS WITHIN
 THE DATE OF AVAILMENT OTHERWISE IT WILL
 BE OF PERSONAL EXPENSE.

Payment Method: **COMPANY**
 Employer: **IPLOY INC.,**
 Charge To: **IPLOY INC.,**
 Remarks: **APRIL**
 Check-up Type: **PRE-EMPLOYMENT**

Other Charges 0.00
 Less : Discount 0.00
Total Amount 650.00



VALIDATED BY:
[Signature]
 Cashier

[Signature]
 Customer Signature

Prime CARE
C E B U

Date printed: 7/13/2019