Prime Care Cebu
IMMEDIATE MEDICAL & DENTAL CARE CENTER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [ ] Pre-Employment [ ]

Last Name Antonio **First Name** Jonas **M.I.** S. **Date** 8/29/19

Address Punta Labangon Cebu City **Age** 26 **Civil Status** Single **Sex** male

Place of Birth Valencia City Bukidnon **Date of Birth** 06/24/1993 **Insurance Provider**

Occupation CSR **Name of Company** IPlay **Tel. / Mobile no.** 09950092437

PHYSICAL EXAMINATION

Temp.: 36.1 °C PR: 81 bpm RR: 17 bpm BP: 120/80 mmHg Ht: 164 cm Wt: 65.2 kgs.

Visual Acuity: Right Eye: 20/ 20 Left Eye: 20/ 20-1 BMI: 24.2 Underweight: [ ] Overweight: [ ]

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

MEDICAL HISTORY

Past Medical History: ~ / Asthma

Family History: (-)

Previous Hospitalization: (-)

Menstrual History: N/A Parity LMP: Contraceptive Use:

Review of Systems	Normal	Findings	Review of Systems	Normal	Findings
Head & Scalp	✓		Lungs	✓	
Eyes & Ears	✓		Heart	✓	
Skin / Allergy	X		Abdomen	✓	
Nose & Sinuses	✓		Genitals	✓	
Mouth / Teeth / Tongue	✓		Extremities	✓	
Neck / Nodes	✓		Reflexes	✓	
Chest/ Breast	✓		BPE	✓	

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	✓		ECG	NA	
CBC	✓		Other Procedures:		
Urinalysis	✓		HBsAg	✓	
Fecalysis	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
[ ] 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

8/29/19
Date Examined

Mercedes Ramos, M.D.
Medical Examiner
License No.: 0014

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.: 171964 SO No.: 00767930

Name: ANTONIO, JONAS SALAZAR Age: 26 yrs. Date: 8/29/2019

Requested by: Sex: MALE

Patient Status: Company: IPLOY INC.,

Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

			Normal Values
( ) WBC	5,000	/mm^3	5,000-10,000 /mm^3
( ) RBC	5.19	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	15.57	gm%	F: 12-15gm% M: 14-17gm%
( ) Hematocrit	46.70	gm%	F: 38-48vol% M: 40-50vol%
Differential Count			
Neutrophils	56	%	45-65%
Lymphocytes	33	%	20-35%
Monocytes	6	%	2-9%
Eosinophils	5	%	0-6%
Basophils		%	0-2%
Platelet Count	275,000	/mm^3	150,000-450,000 /mm^3
Others			

HBsAg Non-Reactive

Anti-HAV IgM

NOTE:

LOVELY DEIGNS R. GLORI, RMT PRC#009
Medical Technologist

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

Medgruppe Polyclinics & Diagnostic Center, Inc.

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

LABORATORY DEPARTMENT

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

No.: 169564 SO No.: 00767930

Name : ANTONIO, JONAS SALAZAR Age : 26 yrs. Date: 8/29/2019

Physician : Sex : MALE

Company : IPLOY INC., Patient Status:

Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Light Yellow
Appearance	Clear
pH	7.5
Specific Gravity	1.015
Glucose	Negative
Protein	Negative

MICROSCOPIC:

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

MISCELLANEOUS:

Pregnancy Test	N/A

OTHERS:

NOTE:

LOVELY DEIGNS R. GLORI, RMT PRC#009
Medical Technologist

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

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QN952993
64

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: 201908290108
Name: ANTONIO, JONAS SALAZAR
Birthdate: 06/29/1993 Age: 26 Gender: M

Transaction Date Time: 9/3/2019 7:33:00AM
Report Date Time: 9/3/2019 6:29:31PM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

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

Test Conducted By

77 JEZEBEL C. CAPIROL-CURATIVO
Analyst

Approved By

DR. PETER SAMSON AZNAR 57
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.
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. LAB ACCESSION NO.

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name _____ √ B. Address: Punta Cebu City √ C. Age: 26 √ D. Sex: M
√ E. Employer Name and Address Iplon, Cebu 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°Cand 38°C?
/ / Yes / / No

Specimen Collection: / / Observed / / Unobserved
Specimen Sampling : / / Single / / Split
Specimen Volume: ___ ml. Physical Appearance: Color: _____

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_____ _____AM/PM ▶
Signature of Collector Time of Collection
ANALYN O. FLORES AUG 29 2019 ▶
(PRINT) Collector's Name (first, MI, Last) Date (Mo/Day/Yr)

SPECIMEN BOTTLE(S) RELEASED TO:
_____
Name of Delivery Service Transferring Specimen to Lab.

RECEIVED AT LAB: ▶
X_____
Signature of Accessioner
ANALYN O. FLORES AUG 29 2019 ▶
(PRINT) Accessioner's Name (First, MI, Last) 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.

√ _____ √ JOMAS S. ANTONIO √ 8 / 29 / 19
Signature of Donor (PRINT) Donor's Name (First, MI, Last) Date (Mo/Day/Yr)

√ Contact No. 09485002427 √ Date of Birth 06 / 24 / 93
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 JEZEBEL C.CAPIROL- CURATIVO, RMT PETER S. AZNAR, M.D., F.P.S.P. AUG 29 2019
Signature & Name of Analyst (First. MI, Last) 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)

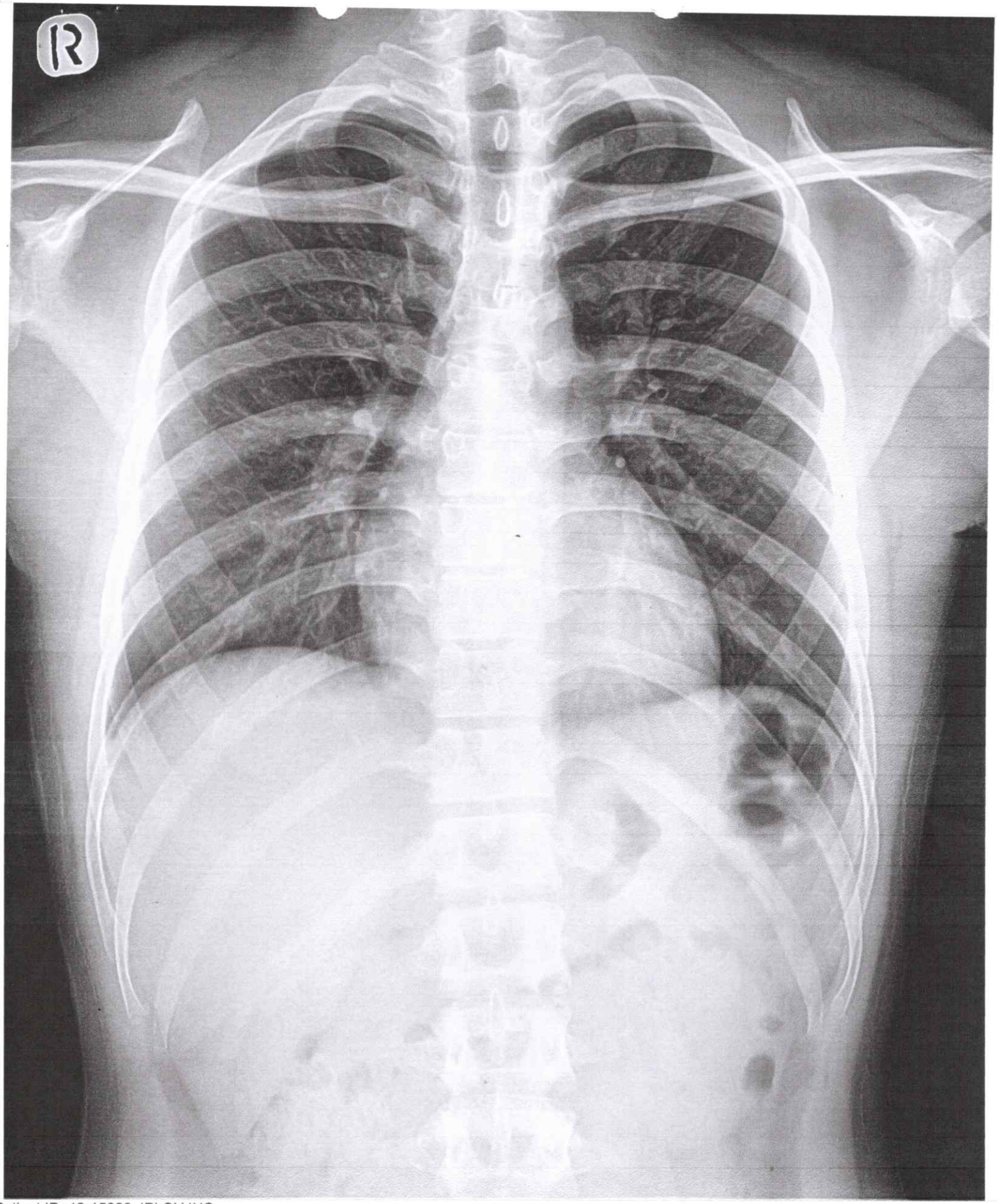
☐ STEP 8 : *TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL*

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

/ / RECONFIRMED FOR: / / 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 (For Positive Sample)



Patient ID: 19-15060 IPLOY INC
Patient Name: ANTONIO,JONAS
Study Date: 08/29/2019