CLINIC SLIP

Employee Name: * PAOLO A	LOUISALAS		Date: 03.06.2020
Employee Number: * 1648		Time In: 11: 42PM	Time Out: 11'. 49pm
Supervisor's Name and signature:	GERALDINE (SUTTEREZ	
Complaint: REEVALUATION (PE	ME)		
Focused History and Physical Exam	: (E) manterari o	neds	
Medication Given:			
RECOMMENDATION: Class A - Advised	to slek count w	apparetant if eyesless	ne ned to be updated.
Clinic Rest	Time/Duration:		
Send Home	Inclusive Dates:		
☐ ER Conduction	Institution:		9
Acknowledgement:	cian	Patien	t's Signature



MEDICAL EXAMINATION RECORD

Annual Physical Examination []			Pre-Emplo	yment []	- VIII -
Last Name AVOUISA		st Name PAOW	M.I CONSON	Date C	01-13-2020
Address PROY. KALUK	ASAN CC. Ag	e 31	Civil Status SN61	F Sex M	
Place of Birth CTU C	Da Da	te of Birth Oo-Co-K	188 Insurance Provider		
Occupation CSR-PH		me of Company Pl	Tel./ Mob	ile no. OAZ	5 1391 0934
Temp.: 35.6 °C PR:	vith/withou	Left Eye: 20/40 teyeglasses) MEDICAL HISTO	BP: 10 60 mmHg BMI: 26.3 Underv Norma	veight: C	Verweight:
Review of Systems	Normal	FINDINGS	Review of Systems	Normal	FINDINGS
Head & Scalp	Norman	FINDINGS	Lungs	Normal	FINDINGS
Eyes & Ears	-		Heart		
Skin / Allergy	1	317M7 N	Abdomen	1	
Nose & Sinuses	1	CATALL STATE OF THE STATE OF TH	Genitals	-	
Mouth / Teeth / Tongue	1		Extremities		96
Neck / Nodes	1		Reflexes	/	
Check / Breast	1		BPE		
	1				
			Rectal		
LABORATORY	Normal	FINDINGS		Normal	FINDINGS
LABORATORY	Normal	FINDINGS	Review of Systems ECG		FINDINGS
		FINDINGS	Review of Systems	Normal WA	FINDINGS
LABORATORY Chest x-Ray	Normal /	FINDINGS	Review of Systems		FINDINGS
LABORATORY Chest x-Ray CBC Urinalysis	X	FINDINGS	Review of Systems		FINDINGS
LABORATORY Chest x-Ray CBC		FINDINGS	Review of Systems		FINDINGS
LABORATORY Chest x-Ray CBC Urinalysis Fecalysis Drug Test I certify that I have examine Classification:	X	Physically fit for all type Physically fit for all type Physically fit for all type Has minor ailment/ defe Needs treatment/ co Treatment optional Physically fit for less streatily curable or offers in Needs treatment/ co assily curable or offers in Treatment optional	Review of Systems ECG Other Procedures cally [] fit [] Unfit for employers of work	oyment. o handicap to ap Overweigh or ailments/defe	plied.
LABORATORY Chest x-Ray CBC Urinalysis Fecalysis Drug Test I certify that I have examine Classification: [] C [] C [] P	LASS A LASS B LASS C LASS D LASS E	Physically fit for all type Physically fit for all type Has minor ailment/ defe Needs treatment/ co Treatment optional Physically fit for less streasily curable or offers Needs treatment/ co Treatment optional Treatment optional Treatment optional Employment at the risk Unfit for employment	Review of Systems ECG Other Procedures cally [] fit [] Unfit for employers of work	oyment. o handicap to ap Overweigh or ailments/defe	plied. t , LBL Result ects.



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, 5000 Philippines Tel Nos. (032) 232-2273 * (032) 266-3246

LABORATORY DEPARTMENT

Pathologist PRC #72410		noiogist 3012	Medical echnologist	
in A	# [H]	RON, RMT	CYRA MÆE A. LAURON, RMT	
			NOTE:	
			Anti-HAV IgM	
			HBsAg	
			Others	
150,000-450,000 /mm ³	00 /mm ³	292,000	Platelet Count	
0-2%	%		Basophils	
0-6%	4 %		Eosinophils	
2-9%	%		Monocytes	
20-35%	44) % *		Lymphocytes	
45-65%	46 %		Neutrophils	
		#	Differential Count	
F: 38-48vol% M: 40-50vol%	10 gm%	41.10	() Hematocrit	
F: 12-15gm% M: 14-17gm%	10 gm%	16.10	() Hemoglobin	
M: 4.0 - 5.3 x 10 9mm ³				
F: 4.0 - 5.1 × 10 ⁶ / mm ³				
M: 4.7 - 6.10 > 10 / 111111				
F: 4.2 - 5.4 × 10 7 mm				
	4.45 × 10° /mm3	4.	() RBC	
4,000-10,000 /mm ³		5,100	() WBC	
Normal Values				
UNT	COMPLETE BLOOD COUNT	OMPLETE	0	
IPLOY INC.,	Charge To: IF			
IPLOY INC.,	Company: IF		Patient Status:	atier
Sex: MALE			Requested by:	Requi
Age: 31 yrs. Date: 01/13/2020		ALQUISALAS, PAOLO CONSON		Name:
SO No.: 00785257			179034	6.:
6-2	License TO OPERATE No.: 07-065-17-AS-2	ense TO OPERA	Lic	



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

No.

Name: ALQUISALAS, PAOLO CONSON

Age: 31 yrs. SO No.: 00785257 Date: 01/13/2020

Company: IPLOY INC., Charge To: IPLOY INC., Physician: Patient Status: Sex: MALE

URINALYSIS

OTHERS:	Amorphous (PO ₄) MISCELLANEOUS: Pregnancy Test	Crystals Amorphous (Urates)	Mucus Threads Bacteria	RBC / hpf WBC / hpf Epith. Cells / hpf Casts	Specific Gravity Glucose Protein MICROSCOPIC:	MACROSCOPIC: Color Appearance pH
	N/A	Rare	Rare	0-1 0-1 Rare	1.020 Negative Negative	Yellow Clear 6.0

IRISTIAN DEAN T. SORRONDA, RMT

PETER S. AZNAR, M.D., F.P.S.P.

Pathologist PRC #72410



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www.Medgruppe.Com
DOH-POEA-MARINA ACCREDITED NO. RLS-584-08-04

Patient Name: ALQUISALAS, PAOLO CONSON X-Ray No./Case No.: 20-00767

Date of Birth: 6/6/1988 Age: 31 Sex: MALE Date: JAN 13,2020

Company: IPLOY INC., Examination/Procedure: CHEST PA

Service Order No.: 0000785257

X-RAY REPORT

FINDINGS:

Both lungs are clear. The heart is not enlarged. The pulmonary vessels are within normal limits. The trachea is in the midline. Both hemidiaphragms are sharp and distinct. The included bones are unremarkable.

REMARKS:

> NORMAL CHEST

Finding is based on radiographic interpretation. Clinical correlation is suggested.

PATRICK IAN DUMALAGAN

Date printed: 1/13/2020

KAREN SITACA-DIÑO, MD FPCR PRC#0100318

Radiologist



DEPARTMENT OF HEALTH MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.

2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU

Phone Number 232-2273

DRUG TEST REPORT

RI950688

CCF No:

Birthdate:

202001130005

Name:

06/06/1988

ALQUISALAS, PAOLO CONSON Age: 31

Gender: M

Transaction Date Time: 1/14/2020 12:29:00PM

Report Date Time:

1/14/2020 5:09:13PM

Test Method

TEST KIT

Purpose

60

Requesting Parties

Private Employment

Result

IPLOY

Drug/Metabolite	Result	Remarks	
METHAMPHETAMINE	NEGATIVE		
TETRAHYDROCANNABINOL	NEGATIVE		

Test Conducted By

JEZEBEL C. GAPIROL-CURATIVO

DR. PETER SANSON AZNAR

Approved By

56

Analyst

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.

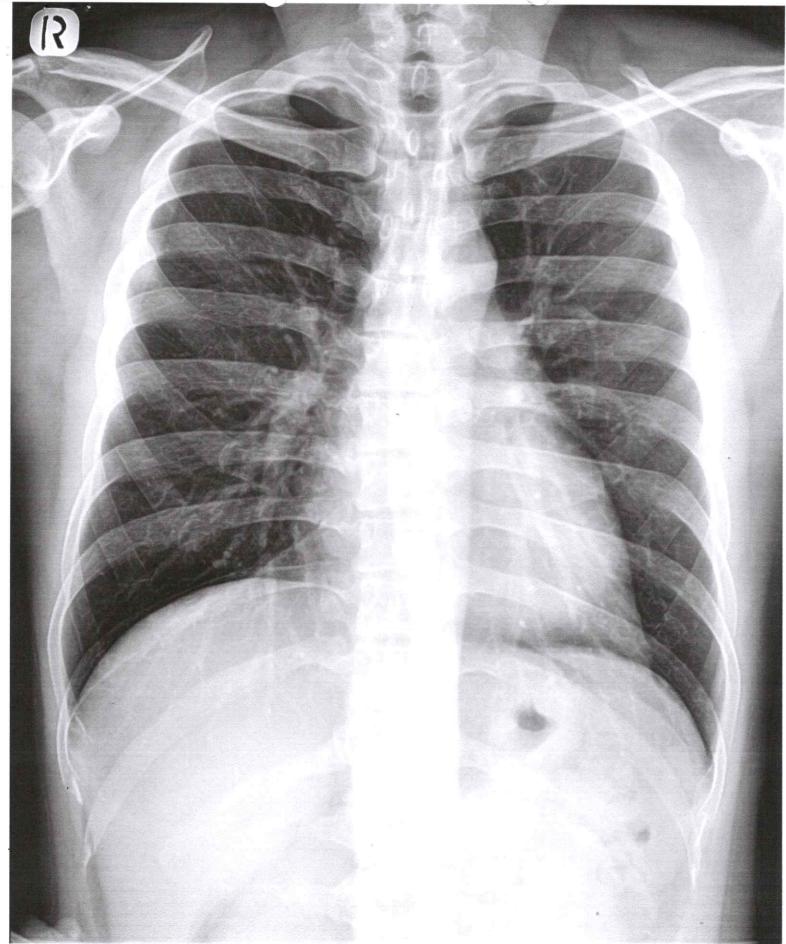
2ND Floor, APM Centrale Mall, Soriano Ave., NRA, Brgy. Mabolo, Cebu City, Philippines 6000
Tel. No. (032) 232-2273 Fax: (032) 234-2273
CUSTODY AND CONTROL FORM
(Form DT-002A - COPY FOR THE DONOR)

SPECIMEN ID NO.

LAB ACCESSION NO.

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER	REPRESENTATIVE
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A Clert Vibror's Subjects Name C. Resident of Test C. Residen	DEDO C. AGUICALS DON DA LIDIGATO C. O. II
A. Reissen for Teet: Committee Commit	√ A. Client's/Donor's/Subject's Name
// Peer Accident // Pee	V. E. Employer Name and Address Programmer Speciments
/ Bood / Cherts(specify) / Feat Accident / Cherts (specify) / Feat Accident / Cherts (specify) / Che	
## Procession of Perfermed: / THIC, COC, PCP, OPI, AMP / THIC & MET Only / Others (specify) STEP 2 COMPLETED BY COLLECTOR Read specimen temperature within 4 minutes. Specimen Collection: Specimen C	//Blood //Return to Duty //Mandatory //Post Accident
STEP 2 COMPLETED BY COLLECTOR Read specimen temperature within 4 minutes. Is temperature within 4 minutes. Is temperature between 37 Cand 38°C? 1/Yes // 1/No Specimen Sampling: // Single // 1/No Specimen Sampling: // 1/No Specimen Sa	
Red specimen temperature within 4 minutes. Is temperature within 4 minutes. Is temperature between 3°C-2nd 36°C? Yes Yes	11. Stug resid to be retrollined. 7 7 1110, 000, ror, or i, mile 7 7 1110 d this rolling 7 7 outles (specify)
Is temperature between 27 cand 38°C? // Yes // No Specimen Sampling: // Single // Specimen Sampling: // Specim	STEP 2 COMPLETED BY COLLECTOR
Is temperature between 32°C and 38°C? // Yes // No Specimen Sampling: // Single // Popical Appearance: Color: // Positive // No REMARKS STEP 3: Colector affixes bottle seal(s) to bottle(s). Colector dates seal(s). Donor completes STEP 5. STEP 4: CHAN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY. Locatify that the specimen given to me by the advoor 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 Time of Collection Time of Collection Name of Delivery Service Transferring Specimen to Lab. SEPCIMEN BOTTLE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab. SEPCIMEN BOTTLE(S) RELEASED TO: (a) Seal Intact / / Yes / / No (b) Transport Device Signature & Popical Signature & Printed Name of Receiving Person Print Name (First, MI, Last) Date (Mo/Day/Yr) STEP & COMPLETED BY THE DONOR Completed By HEAD OF SCREENING LABORATORY In accordance with applicable Department of Health requirements, my determination/verification is: // NEGATIVE / POSITIVE / / TEST CANCELLED // Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Popical Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Popical Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Date (Mo/Day/Yr) Date (Mo/Day/Yr) Date (Mo/Day/Yr) Date (Mo/Day/Yr) Signature & Name of Analyst (First, MI, Last) Date (Mo/Day/Yr) Da	Read specimen temperature within 4 minutes. Specimen Collection: / / Observed / / Unobserved Other Observation (Enter Remark)
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 LORDING TO BY COLLECTOR AND COMPLETED BY LABORATORY LORDING TO BY LABORATORY LORDING TO BY CONTROL OF CUSTODY CUSTODY CONTROL OF CUSTODY CUST	Is temperature between 32°Cand 38°C? Specimen Sampling: / / Single / / Split
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	REMARKS
Signature of Collector Time of Collection Name of Delivery Service Transferring Specimen to Lab. Separature of Accessioner Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Step 5 CoMPLETED BY THE DONOR (PRINT) Collector, that I have not adulterated Thranty pentiner, each specimen bottle used was sealed with a tamper-evident seal in my presonate of the pentine of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed with a tamper-evident seal in my presonate of the specimen bottle used was sealed	
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Signature of Collector Time of Collection Date (Mo/Day)Yr) Name of Delivery Service Transferring Specimen to Lab.	
Signature of Accessioner (a) Seal Intact / / yes / / No (b) Transport Device (c) Description Signature & Printed Name of Receiving Person Print Name (First, Mi, Last) Date (Mo/Day/Yr) STEP 5 COMPLETED BY THE DONOR I certify fish produced my riging-specimen to the collector; that I have not adulterated the any paginer; each specimen bottle used was sealed with a tamper-evident seal in my presenced and that Information provided on this form and on the affired Science of Science of Birth (C) (1) Use of Birth (C) (1	XAM/PM SPECIMEN BOTTLE(S) RELEASED TO: Signature of Collector Time of Collection
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(PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Signature & Printed Name of Receiving Person Print Name (First, MI, Last) Date (Mo/Day/Yr) STEP 5 COMPLETED BY THE DONOR Locity that I provided my urige specimen to the collector; that I have not stutterated through my urige specimen bottle used was sealed with a tamper-evident seal in my presenced and the hintogradion provided on this form and on the office of the collector. The presence of the hintogradion provided on this form and on the office of the collector. The presence of the hintogradion provided on this form and on the office of the collector. The presence of the hintogradion provided on this form and on the office of the collector. Signature of Print Name (First, MI, Last) Date (Mo/Day/Yr) Date of Birth Co. On the Collector of the	X (a) Seal Intact / / Yes / / No
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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: // NEGATIVE / POSITIVE / TEST CANCELLED / REFUSAL TO TEST BECAUSE: // OTHERS (Specify) REMARKS X JEZEBEL C. CAPIROL-CURATIVO, RMT Signature & Name of Head of Laboratory (First. Mi, Last) 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 Date (Mo/Day/Yr) Date (Mo/Day/Yr) DISTEP 8: TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRI. In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is: // RECONFIRMED FOR: // THC // MET // OTHERS // FAILED TO CONFIRM - REASON // THE // FAILED TO CONFIRM - REASON // THE // THE // MET // THE // MET // FAILED TO CONFIRM - REASON // THE // THE // MET // THE // MET // THE // MET // THE // MET // FAILED TO CONFIRM - REASON // THE // THE // THE // MET // THE // MET // THE // MET // THE // THE // MET // THE // THE // THE // THE // MET // THE // TH	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.
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 REMARKS	√ Contact No. O Date of Birth O Day Yr
In accordance with applicable Department of Health requirements, my determination/verification is: / / NEGATIVE / / POSITIVE / / TEST CANCELLED / / REFUSAL TO TEST BECAUSE: / / OTHERS (Specify) / ADULTERATED / / SUBSTITUTED / / OTHERS (Specify) / OTHERS (Specify) X	Additional information may be asked from you by the laboratory particularly on drugs and medications.
/ NEGATIVE	STEP 6: COMPLETED BY HEAD OF SCREENING LABORATORY
REMARKS	In accordance with applicable Department of Health requirements, my determination/verification is:
X	
X JEZEBEL C. CAPIROL-CURATIVO, RMT 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: //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) Date (Mo/Day/Yr) Date (Mo/Day/Yr) Date (Mo/Day/Yr) Date (Mo/Day/Yr) CSTEP 8: TO BF COMPLETED BY NATIONAL REFERENCE LABORATORY (NPL 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	/ / OTHERS (Specify)
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) Date (Mo/Day/Yr) 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 / / OTHERS	REMARKS
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Patient ID: 20-00767 IPLOY
Patient Name: ALQUISALAS,PAOLO
Study Date: 01/13/2020