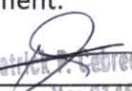
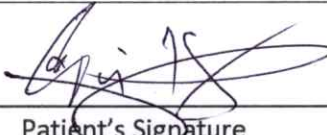


## CLINIC SLIP

Employee Name: * PAOLO ALQUISALAS		Date: 03-06-2020
Employee Number: * 1648	Time In: 11:42AM	Time Out: 11:49AM
Supervisor's Name and signature: * STERALDINE GUTIEREZ		
Complaint: REEVALUATION (PEME)		
Focused History and Physical Exam: (-) consabids, (E) mantenimi needs		
Medication Given: none		
RECOMMENDATION: Class A - Advised to seek consult w/ optometrist if eyewear need to be updated.		
<input type="checkbox"/> Clinic Rest	Time/Duration:	
<input type="checkbox"/> Send Home	Inclusive Dates:	
<input type="checkbox"/> ER Conduction	Institution:	
Acknowledgement:		
 James Patrick P. Sabrecas, M.D. Name & Signature of NOD/Physician		 Patient's Signature

**MEDICAL EXAMINATION RECORD**

Annual Physical Examination

Pre-Employment

Last Name ALOUISALAS First Name PAOLO M.I. CONSON Date 01-13-2020  
 Address PROY. KALUNASAN CC Age 31 Civil Status SINGLE Sex M  
 Place of Birth CEBU CITY Date of Birth 06-06-1988 Insurance Provider \_\_\_\_\_  
 Occupation CSR-PHONE Name of Company IPLOY Tel./ Mobile no. 0945 1391 0936

**PHYSICAL EXAMINATION**

Temp.: 35.6 °C PR: 68 bpm RR: 14 cpm BP: 110/60 mmHg Ht: 165 cm Wt: 69 kgs  
 Visual Acuity: Right Eye: 20/50 Left Eye: 20/40 BMI: 25.3 Underweight:  Overweight:   
 (with/without eyeglasses) Normal weight:  Obese:

**MEDICAL HISTORY**

Family History: Chronic on or (then CDM)  
 Previous Hospitalization: \_\_\_\_\_  
 Menstrual History: \_\_\_\_\_ y.o Parity \_\_\_\_\_ LMP: \_\_\_\_\_ Contraceptive Use: \_\_\_\_\_

Review of Systems	Normal	FINDINGS	Review of Systems	Normal	FINDINGS
Head & Scalp	/		Lungs	/	
Eyes & Ears	/		Heart	/	
Skin / Allergy	/	<u>ALLERGY</u>	Abdomen	/	
Nose & Sinuses	/		Genitals	/	
Mouth / Teeth / Tongue	/		Extremities	/	
Neck / Nodes	/		Reflexes	/	
Check / Breast	/		BPE	/	
			Rectal	/	

LABORATORY	Normal	FINDINGS	Review of Systems	Normal	FINDINGS
Chest x-Ray	/		ECG	<u>NA</u>	
CBC	<u>X</u>		Other Procedures		
Urinalysis	/				
Fecalysis					
Drug Test	<u>NA</u>				

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 applied.  
 Needs treatment/ correction EOR, Overweight, UBL Result  
 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 \_\_\_\_\_  
 Treatment optional 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. 120119



# Medgrupp Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

2nd Level, APH Central, A. Soriano Jr. Ave., N.R.A.  
Mabolo, Cebu City, 6000 Philippines  
Tel Nos. (032) 232-2273 • (032) 266-3246

## LABORATORY DEPARTMENT

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

No.: 179034

SO No.: 00785257

Name: ALQUISALAS, PAOLO CONSON

Age: 31 yrs.

Date: 01/13/2020

Requested by:

Company: IPLOY INC.,

Sex: MALE

Charge To: IPLOY INC.,

## COMPLETE BLOOD COUNT

		Normal Values
( ) WBC	5,100 /mm <sup>3</sup>	4,000-10,000 /mm <sup>3</sup>
( ) RBC	4.45 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	16.10 gm%	F: 12-15gm% M: 14-17gm%
( ) Hematocrit	41.10 gm%	F: 38-48vol% M: 40-50vol%
<b>Differential Count</b>		
Neutrophils	46 %	45-65%
Lymphocytes	44 %	20-35%
Monocytes	6 %	2-9%
Eosinophils	4 %	0-6%
Basophils	%	0-2%
Platelet Count	292,000 /mm <sup>3</sup>	150,000-450,000 /mm <sup>3</sup>
Others		

HBsAg

Anti-HAV IGM

NOTE:

CYRA MAE A. LAURON, RMT

Medical Technologist  
Lic. No. 0093012

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

Pathologist  
PRC #72410



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Mabolo, Cebu City, 6000 Philippines  
Tel Nos. (032) 232-2273 • (032) 266-3246

## LABORATORY DEPARTMENT

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

No.: 176782

SO No.: 00785257

Name: ALQUISALAS, PAOLO CONSON

Age: 31 yrs.

Date: 01/13/2020

Physician:

Company: IPLOY INC.,

Sex: MALE

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	0-1
Epith. Cells / hpf	Rare
Casts	
Mucus Threads	Few
Bacteria	Rare
Crystals	
Amorphous (Uratates)	Rare
Amorphous (PO <sub>4</sub> )	
MISCELLANEOUS:	
Pregnancy Test	N/A
OTHERS:	

NOTE:

CHRISTIAN DEAN T. SORRONDA, RMT

Medical Technologist  
Lic. No. 0093000

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

Pathologist  
PRC #72410





# 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

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  
Referred by: IPLOY INC., 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  
Encoder

  
KAREN SITACA-DIÑO, MD FPCR PRC#0100318  
Radiologist

Date printed: 1/13/2020



RI950688  
94

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

CCF No: 202001130005  
Name: ALQUISALAS, PAOLO CONSON  
Birthdate: 06/06/1988 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  
Private Employment

Requesting Parties  
IPLOY

Result

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

Approved By

60 JEZEBEL C. CAPIROL-CURATIVO

DR. PETER SANSON AZNAR

56

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.

LAB ACCESSION NO.

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name	<u>PAD C. AZQUISALAS</u>	√ B. Address:	<u>BIGY. KALUOGAN CC.</u>	√ C. Age:	<u>31</u>	√ D. Sex:	<u>M</u>
√ E. Employer Name and Address	<u>IPOLY 9TH FLOOR - AYALA CEBU BUSINESS PARK</u>						
F. Type of Specimen:							
/ / Urine		/ / Pre-employment		/ / Random		/ / Reasonable Suspicion/Cause	
/ / Blood		/ / Return to Duty		/ / Mandatory		/ / Post Accident	
/ / Others(specify)				/ / 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.	Specimen Collection: / / Observed / / Unobserved	Other Observation (Enter Remark)
Is temperature between 32°C and 38°C?	Specimen Sampling: / / Single / / Split	
/ / Yes / / No	Specimen Volume: ___ ml. Physical Appearance: Color: _____	

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:  _____ Name of Delivery Service Transferring Specimen to Lab.
(PRINT) Collector's Name (first, MI, Last)	_____/_____/_____ Date (Mo/Day/Yr)	

RECEIVED AT LAB:	STATUS OF THE SPECIMEN	SPECIMEN BOTTLE(S) RELEASED TO:
X _____ Signature of Accessioner	(a) Seal Intact / / Yes / / No (b) Transport Device _____ (c) Description _____	Signature & Printed Name of Receiving Person
(PRINT) Accessioner's Name (First, MI, Last)	_____/_____/_____ Date (Mo/Day/Yr)	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>PAD C. AZQUISALAS</u> (PRINT) Donor's Name (First, MI, Last)	<u>01/13/2020</u> Date (Mo/Day/Yr)
√ Contact No. <u>0915 391 0934</u>		√ Date of Birth <u>06/06/1989</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:

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

REMARKS \_\_\_\_\_

X <u>JEZEBEL C. CAPIROL-CURATIVO, RMT</u> Signature & Name of Analyst (First, MI, Last)	<u>PETER S. AZNAR, M.D., F.P.S.P.</u> 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)

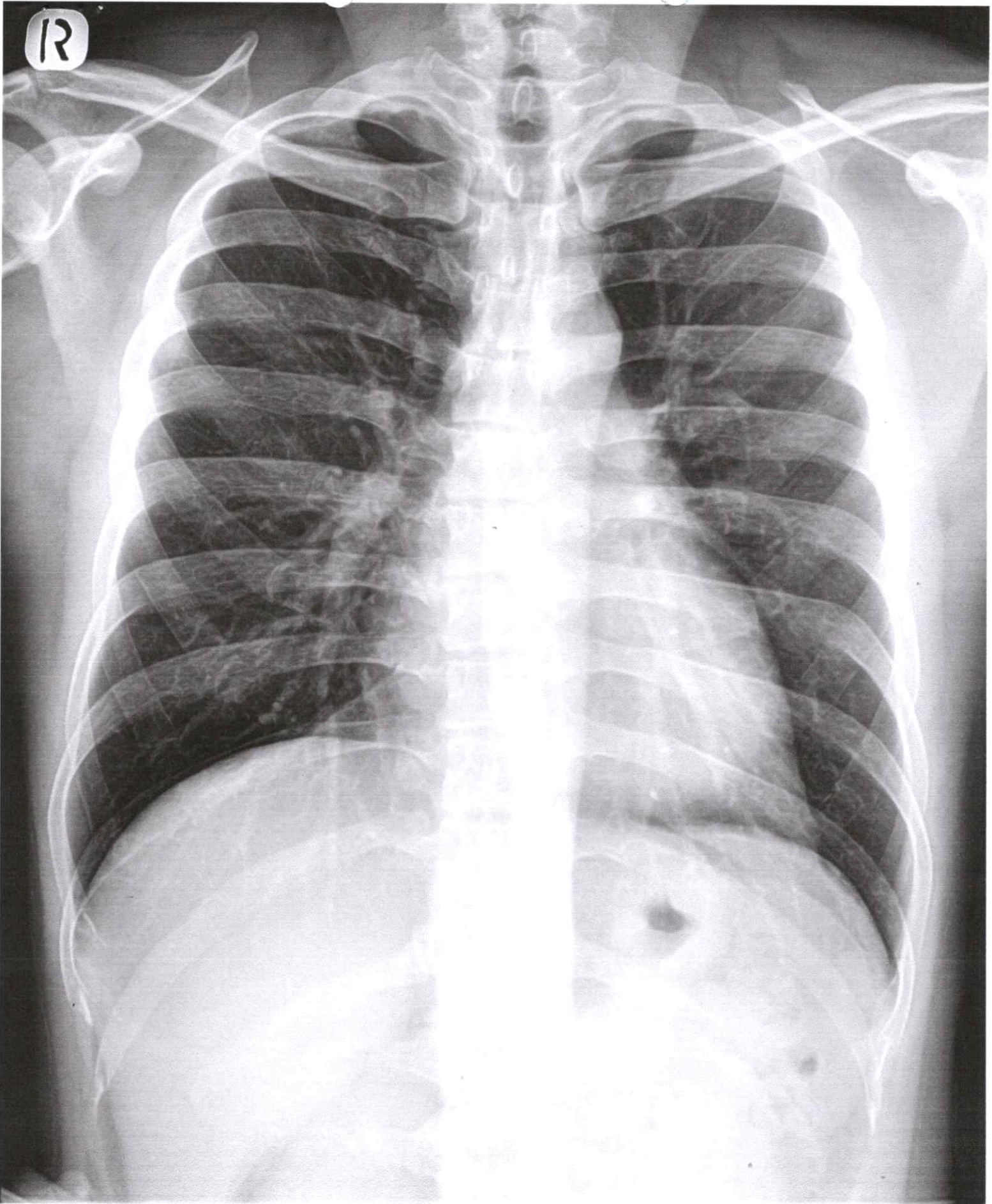
In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

/ / 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)
---------------------------------	--	---------------------------------------

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





Patient ID: 20-00767 IPLOY  
Patient Name: ALQUISALAS, PAOLO  
Study Date: 01/13/2020