CLINIC SLIP

Employee Name: Mikhail Caleb Ab		Date: 03-07-20
Employee Number: 01659	Time In: 12:26AM	Time Out: 12:25AM
Supervisor's Name and signature: Roy Bontiq		
Complaint: REEVALUATION (PE)		
Focused History and Physical Exam: (-) cerebral (-) meningeal pink conjunctiva, pink mucous membrane, CRT < 2sec.		
Medication Given: none		
RECOMMENDATION: Cleared		
☐ Clinic Rest	Time/Duration:	
☐ Send Home	Inclusive Dates:	
☐ ER Conduction	Institution:	

Acknowledgement:

James Patrick P. Cebrecus, M.D.
License No: 0146580

Name & Signature of NOD/Physician

Patient's Signature

Prime Care CE
IMMEDIATE MEDICAL & DENTAL CARE CENTER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [ ] Pre-Employment [✓]

Last Name ALO First Name MIKHAIL CALEB M.I O Date 01/08/20

Address 213 TRES DE ABRIL ST. LABANGON, CEBU Age 24 Civil Status SINGLE Sex M

Place of Birth LAS PIÑAS CITY Date of Birth 10/08/95 Insurance Provider

Occupation CSR Name of Company iPlay Tel./ Mobile no. 09959943601

PHYSICAL EXAMINATION

Temp.: 36.8 °C PR: 82 bpm RR: 16 bpm BP: 120/80 mmHg Ht: 171 cm Wt: 73.4 kgs

Visual Acuity: Right Eye: 20/20-2 Left Eye: 20/20-2 (with/ without eyeglasses) BMI: 25.1 Underweight: [ ] Overweight: [✓] Normal weight: [ ] Obese: [ ]

MEDICAL HISTORY

Past Medical History: Chicken pox as a child

Family History:

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	✓		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	NA	
CBC	X	Anemia	Other Procedures		
Urinalysis	✓				
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 applied.
[✓] Needs treatment/ correction Overweight, Anemia
[ ] Treatment optional for:

[ ] CLASS C Physically fit for less strenous 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:

Patricia P. Cebreros, M.D.
License No: 0146300
3/04/2020

✓ Patient's Signature

04/08/20
✓ Date Examined

Marian Ramos, M.D.
Medical Examiner
License No. 132114

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.: 176591 SO No.: 00784619

Name : ALO, MIKHAEL CALEB OLLADA Age : 24 yrs. Date: 01/08/2020

Physician : Sex : MALE

Company : IPLOY INC., Patient Status:

Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Yellow
Appearance	Clear
pH	6.0
Specific Gravity	1.010
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)	Rare
Amorphous (PO_4)	

MISCELLANEOUS:

Pregnancy Test	N/A

OTHERS:

NOTE:

CYRA MAE A. LAURON, RMT
Medical Technologist
Lic. No. 0098012

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.: 178856 SO No.: 00784619

Name: ALO, MIKHAEL CALEB OLLADA Age: 24 yrs. Date: 01/09/2020

Requested by: Sex: MALE

Patient Status: Company: IPLOY INC.,

Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

				Normal Values
( ) WBC	5,000	/mm^3		4,000-10,000 /mm^3
( ) RBC	4.52	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	13.93	gm%	*	F: 12-15gm% M: 14-17gm%
( ) Hematocrit	41.80	gm%		F: 38-48vol% M: 40-50vol%
Differential Count				
Neutrophils	54	%		45-65%
Lymphocytes	35	%		20-35%
Monocytes	7	%		2-9%
Eosinophils	4	%		0-6%
Basophils		%	--	0-2%
Platelet Count	345,000	/mm^3		150,000-450,000 /mm^3
Others				

HBsAg

Anti-HAV IgM

NOTE:

CHRISTIAN DEAN T. SORRONDA, RMT
Medical Technologist
Lic. No. 0087004

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) 266-3245
www.Medgruppe.Com
DOH-POEA-MARINA ACCREDITED NO. RLS-584-08-04

Patient Name:	ALO, MIKHAEL CALEB OLLADA			X-Ray No./Case No.:	**20-00470**
Date of Birth:	10/ 8/1995	Age: 24	Sex: MALE	Date:	JAN 8,2020
Company:	IPLOY INC.,			Examination/Procedure:	CHEST PA
Referred by:	IPLOY INC.,			Service Order No.:	0000784619

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:

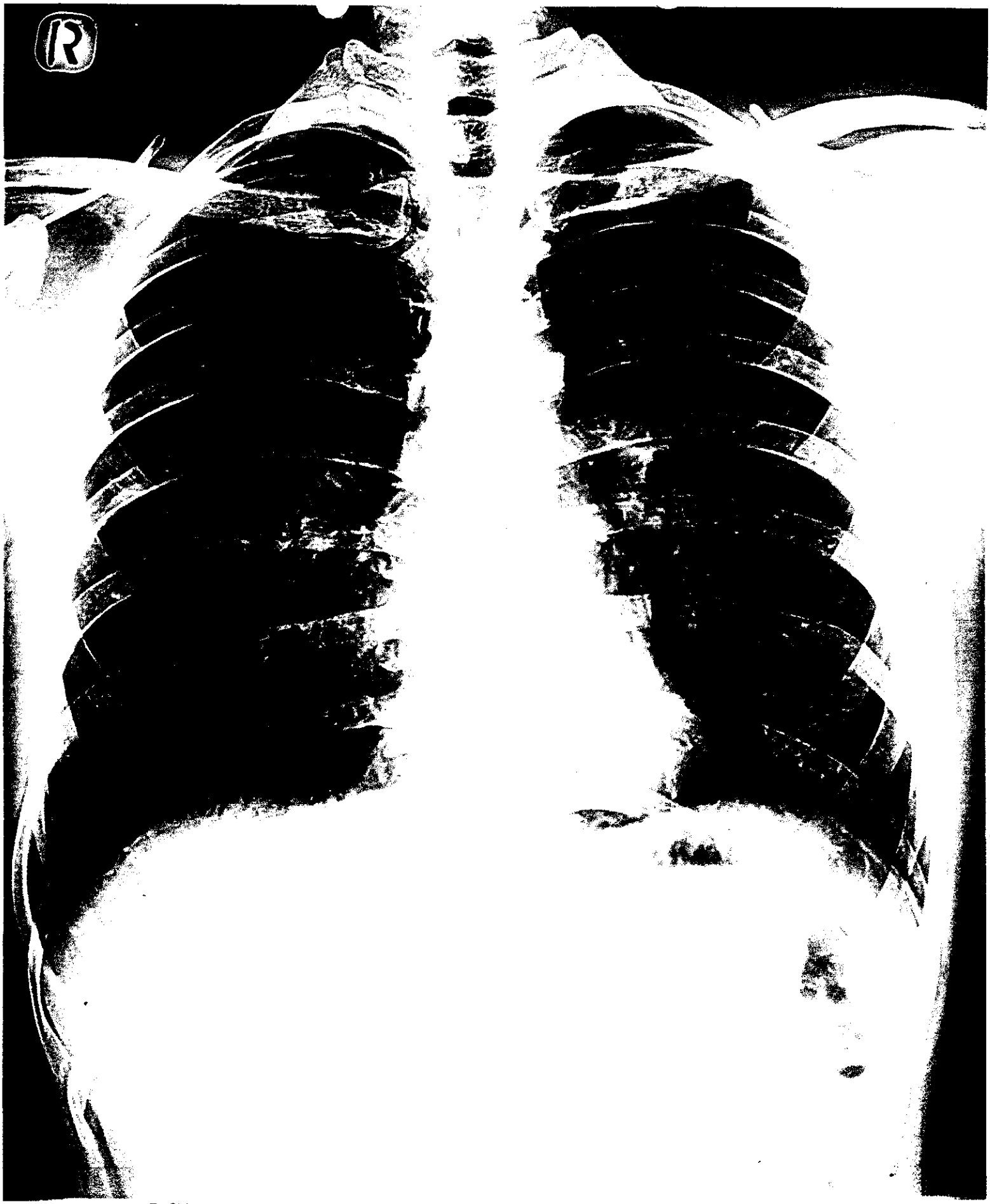
> NORMAL CHEST

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/ 8/2020



Patient ID: 20-00470 IPLOY
Patient Name: ALO,MIKHAEL CALEB
Study Date: 01/08/2020

VT

Report ID: DTO-R03

QL090895
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DEPARTMENT OF HEALTH
MEDG PE POLYCLINICS AND DIAGNOSTIC CENTER, INC.
2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU
Phone Number 232-2273

DRUG TEST REPORT

CCF No: 202001080046
Name: ALO, MIKHAIL CALEB OLLADA
Birthdate: 10/08/1995 Age: 24 Gender: M

Transaction Date Time: 1/9/2020 8:35:00AM
Report Date Time: 1/9/2020 10:27:54AM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

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

Test Conducted By

63 JEZEBEL C. CAPIROL-CURATIVO
Analyst

Approved By

DR. PETER SANSON AZNAR 36
Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

PRIME CARE CEBU

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

√ A. Client's/Donor's/Subject's Name ALO, MIKHAIL CALEB O. √ B. Address: 213 TRES DE ABRIL LABANGON √ C. Age: 24 √ D. Sex: M
√ E. Employer Name and Address 9th Flr. AYALA CENTER CEBU, CEBU BUSINESS PARK
F. Type of Specimen:
√ Urine
/ / Blood
/ / Others(specify) _____
G. Reason for Test :
/ / Pre-employment / / Return to Duty
/√ Random / / Mandatory / / Follow-up
/ / Reasonable Suspicion/Cause / / Post Accident / / 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_____ Signature of Collector
_____ AM/PM Time of Collection
_____ (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
_____ (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.

√ _____ Signature of Donor
√ MIKHAIL CALEB O. ALO (PRINT) Donor's Name (First, MI, Last)
√ 01/08/20 Date (Mo/Day/Yr)
√ Contact No. 09159943601
√ Date of Birth 10/08/95 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 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)
___/___/___ 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)