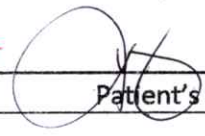


CLINIC SLIP

Employee Name: * Rieth Michael Aho		Date: 03-01-2020
Employee Number: * 01661	Time In: 1:59PM	Time Out:
Supervisor's Name and signature: * Arvie Lauron		
Complaint: Pene (Reevaluation)		
Focused History and Physical Exam: (+) BA - no maintenance ; UA = Nov 2019 - controlled (-) fever, cough, edema		
Medication Given: none		
RECOMMENDATION: Class B		
<input type="checkbox"/> Clinic Rest	Time/Duration:	
<input type="checkbox"/> Send Home	Inclusive Dates:	
<input type="checkbox"/> ER Conduction	Institution:	
Acknowledgement:		
_____ James Patrick P. Cebrecus, M.D. Name & Signature of NOD/Physician		_____ *  Patient's Signature

MEDICAL EXAMINATION RECORD

Annual Physical Examination

Pre-Employment

Last Name AIO First Name Keith Michael M.I. Guillermo Date 01-17-2020
 Address Yoth, Liloan Cebu Age 27 Civil Status Single Sex M
 Place of Birth Davao, Metro Manila Date of Birth 04-01-94 Insurance Provider _____
 Occupation CSR Name of Company 1 play Tel./ Mobile no. 09176042126

PHYSICAL EXAMINATION

Temp.: 36.9 °C PR: 85 bpm RR: 19 bpm BP: 110/70 mmHg Ht: 167 cm Wt: 62 kgs
 Visual Acuity: Right Eye: 20/25 Left Eye: 20/25 BMI: 22.7 Underweight: Overweight:
 (with/ without eyeglasses) Normal weight: Obese:

MEDICAL HISTORY

Past Medical History: (+) MA - last attack: Nov. 2019
 Family History: HPN
 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	/	
CBC	/		Other Procedures	/	
Urinalysis	/				
Fecalysis	/				
Drug Test	NA				

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 BA
 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

Manuel Remon, M.D.
 Medical Examiner
 License No. 121147



Medgrupp Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER
2nd Level, APII Centre, 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.: 07-085-17-AS-2

No.: 177130 SO No.: 00786186
Name: ALO, KIETH MICHAEL GULLERMO Age: 23 yrs. Date: 01/17/2020
Physician: _____ Patient Status: _____ Sex: MALE
Company: IPLOY INC.,
Charge To: IPLOY INC.,

URINALYSIS


MACROSCOPIC:


Color Yellow
Appearance Clear
pH 7.0
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) _____
Amorphous (PO₄) Rare
MISCELLANEOUS: _____
Pregnancy Test N/A
OTHERS: _____

NOTE:


CYRA MAE A. LAURON, RMT
Medical Technologist
Lic. No. 0095012


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



Medgrupp Polyclinics & Diagnostic Center, Inc.

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2nd Level, APII Centre, A. Soriano Jr. Ave., N.R.A
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Tel Nos: (032) 232-2273 • (032) 266-3246

LABORATORY DEPARTMENT

License TO OPERATE No.: 07-085-17-AS-2

No.: 179443 SO No.: 00786186
Name: ALO, KIETH MICHAEL GULLERMO Age: 23 yrs. Date: 01/17/2020
Requested by: _____ Patient Status: _____ Sex: MALE
Company: IPLOY INC.,
Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT


() WBC 9,300 /mm³ 4,000-10,000 /mm³
() RBC 5.75 x 10⁶ /mm³ Adult
F: 4.2 - 5.4 X 10⁶ /mm³
M: 4.7 - 6.10 X 10⁶ /mm³
Pedia
F: 4.0 - 5.1 X 10⁶ /mm³
M: 4.0 - 5.3 x 10⁶ /mm³


() Hemoglobin 16.60 gm% F: 12-15gm% M: 14-17gm%
() Hematocrit 50.00 gm% F: 38-48vol% M: 40-50vol%

Differential Count
Neutrophils 50 % 45-65%
Lymphocytes 37 % 20-35%
Monocytes 8 % 2-9%
Eosinophils 5 % 0-6%
Basophils _____ % 0-2%
Platelet Count 197,000 /mm³ 150,000-450,000 /mm³
Others _____

HBSAg _____
Anti-HAV IGM _____

NOTE:


REXYN G. BATAWANGHUG, RMT
Medical Technologist
Lic. No. 0095484


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: ALO, KIETH MICHAEL GUILLERMO X-Ray No./Case No.: 20-01290
Date of Birth: 6/ 1/1996 Age: 23 Sex: MALE Date: JAN 17,2020
Company: IPLOY INC., Examination/Procedure: CHEST PA
Referred by: IPLOY INC., Service Order No.: 0000786186

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.


DARYL S. RAGASAJO

Encoder


KAREN SITACA-DIÑO, MD FPCR-PRC#0100318

Radiologist

VI



QK950196
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DEPARTMENT OF HEALTH
MEDGRUPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.
2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU

Phone Number 232-2273

DRUG TEST REPORT

CCF No: 202001170023
Name: ALO, KIETH MICHAEL GUILLERMO
Birthdate: 06/01/1996 Age: 23 Gender: M

Transaction Date Time: 1/18/2020 7:08:00AM
Report Date Time: 1/18/2020 10:35:28AM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

<i>Drug/Metabolite</i>	<i>Result</i>	<i>Remarks</i>
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

93 JEZEBEL C. CAPIROL-CURATIVO

Analyst

Approved By

DR. PETER SANSON AZNAR

Head of Laboratory

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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. 406

LAB ACCESSION NO. 01170023

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

✓ A. Client's/Donor's/Subject's Name _____	✓ B. Address: <u>Ayala, Cebu</u>	✓ C. Age: <u>27</u>	✓ D. Sex: <u>M</u>
✓ E. Employer Name and Address _____			
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"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Return to Duty <input type="checkbox"/> Mandatory <input type="checkbox"/> Post Accident <input type="checkbox"/> Follow-up <input type="checkbox"/> Others (specify) _____	
H. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input 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>10ml</u> 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	Time of Collection _____ AM/PM	SPECIMEN BOTTLE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab. _____
(PRINT) Collector's Name (first, MI, Last)	Date (Mo/Day/Yr)	
X _____ Signature of Accessioner	Time of Collection _____ AM/PM	SPECIMEN BOTTLE(S) RELEASED TO: Signature & Printed Name of Receiving Person Print Name (First, MI, Last) Date (Mo/Day/Yr)
(PRINT) Accessioner's 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 ✓ With Michael G. Pio
(PRINT) Donor's Name (First, MI, Last)

✓ Contact No. 6917604222 ✓ Date of Birth 06/01/1996
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 JEZABEL 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: FAILED TO CONFIRM – REASON _____
 THC MET OTHERS _____

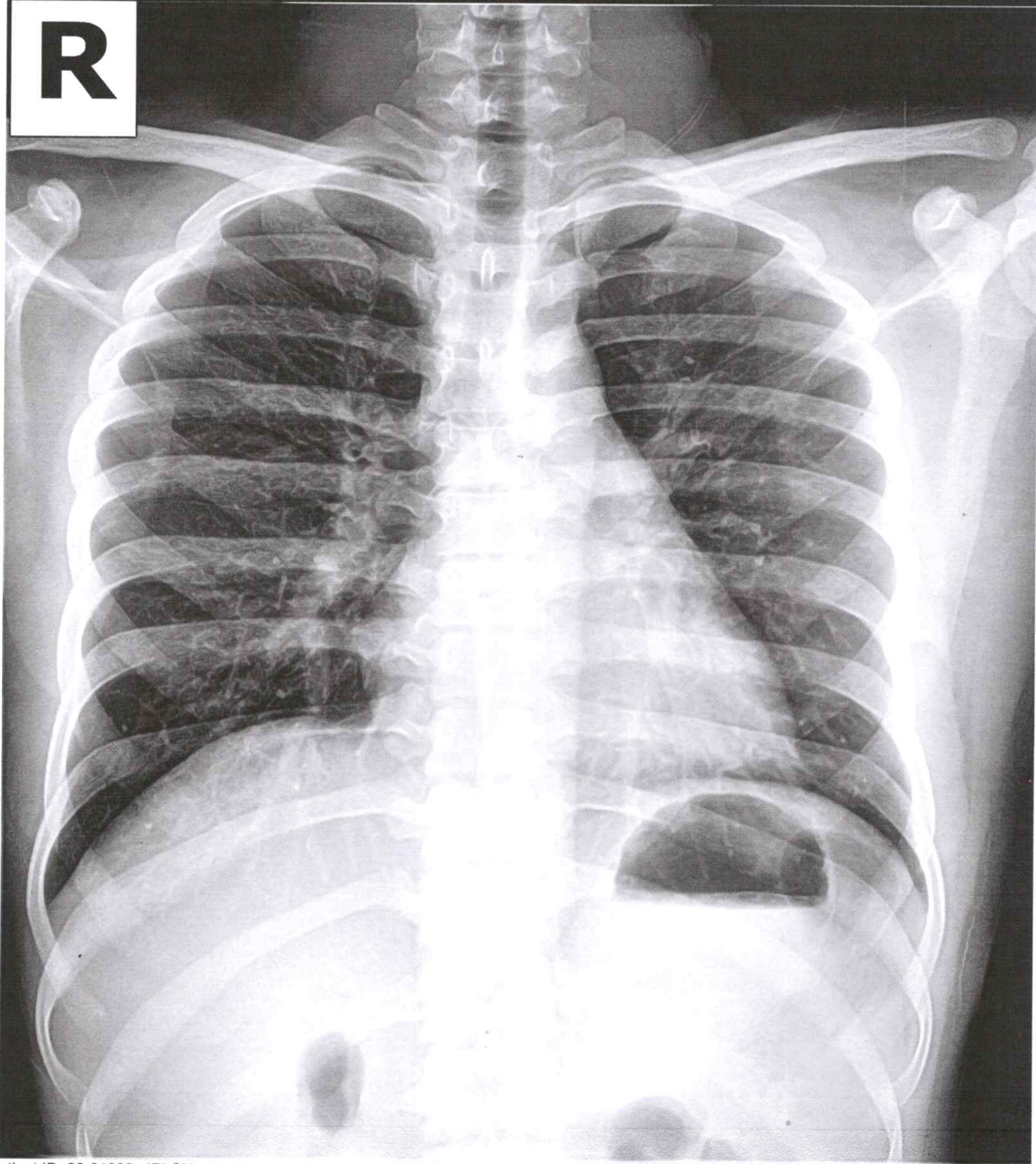
X _____
Signature of Analyst

(PRINT) Signature & Name of Head of Laboratory (First, MI, Last)

Date (Mo/Day/Yr) _____

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)

R



Patient ID: 20-01290 IPLOY
Patient Name: ALO, KIETH MICHAEL
Study Date: 01/17/2020