ANNEX – C
A.O. No. 2013-0006

NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL CERTIFICATE FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department of Health (DOH)

SURNAME/LAST NAME:	GIVEN NAME:	MIDDLE NAME
Acosta	Celia	Moran

AGE:	DATE OF BIRTH:	PLACE OF BIRTH:	NATIONALITY:
37	28 DAY 2 MONTH 1986 YEAR	Muntinlupa	Filipino

GENDER: MALE ☐ FEMALE ☒	CIVIL STATUS: SINGLE ☒ MARRIED ☐	RELIGION:
		Roman Catholic

ADDRESS: 3175-F somewhere St., cor. Dito, Muntinlupa City

PASSPORT NUMBER:	COUNTRY OF DESTINATION:
XDD 975	Canada

POSITION APPLIED FOR:	EMPLOYER/COMPANY/RECRUITMENT AGENCY (IF APPLICABLE):
Psychiatrist	Samplecorp

SATISFACTORY HEARING?	YES ☐	NO ☐
SATISFACTORY SIGHT?	YES ☐	NO ☐
SATISFACTORY COLOR VISION? (WHEN REQUIRED)	YES ☐	NO ☐
SATISFACTORY PSYCHOLOGICAL TEST?	YES ☐	NO ☐
IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY LANDBASED OVERSEAS WORK OR TO RENDER THE APPLICANT UNFIT FOR SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS?	YES ☐	NO ☐

PHOTO
(MUG SHOT)
PASSPORT SIZE

OFFICIAL STAMP

THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO:

Celia M. Acosta
(NAME OF APPPLICANT)

RESULT:

FIT ☒ UNFIT ☐

Juan Dela Cruz
Name and Signature of Examining/Authorized Physician

Date of Examination: 17/09/2019

Approved by:

Jonathan Dela Cruz
Medical Director

I HAVE READ AND UNDERSTOOD THE CONTENTS OF THE ABOVE AND THE INTEGRAL NOTES HEREOF.

APPLICANT'S NAME AND SIGNATURE: Celia M. Acosta **DATE:** _____
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE OF PEME CERTIFICATE:	**DATE OF EXPIRATION OF PEME CERTIFICATE:**
DAY MONTH YEAR	(Filling out this field is not mandatory.) DAY MONTH YEAR