

NAME OF CLINIC

DOH ACCREDITATION NUMBER

Clinic Address

Clinic Contact Information

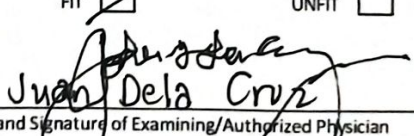
Email Address

MEDICAL CERTIFICATE FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department of Health (DOH)

SURNAME/LAST NAME: <u>Acosta</u>		GIVEN NAME: <u>Celia</u>		MIDDLE NAME: <u>Moran</u>
AGE: <u>37</u>	DATE OF BIRTH: <u>28</u> DAY <u>2</u> MONTH <u>1986</u> YEAR		PLACE OF BIRTH: <u>Muntinlupa</u>	NATIONALITY: <u>Filipino</u>
GENDER: MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	CIVIL STATUS: SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/>		RELIGION: <u>Roman Catholic</u>	
ADDRESS: <u>3175-F Somewhere St., cor. Dito, Muntinlupa City</u>				
PASSPORT NUMBER: <u>XDD 975</u>		COUNTRY OF DESTINATION: <u>Canada</u>		
POSITION APPLIED FOR: <u>Psychiatrist</u>		EMPLOYER/COMPANY/RECRUITMENT AGENCY (IF APPLICABLE): <u>Samplecorp</u>		

SATISFACTORY HEARING?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SATISFACTORY SIGHT?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SATISFACTORY COLOR VISION? (WHEN REQUIRED)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SATISFACTORY PSYCHOLOGICAL TEST?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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 <input type="checkbox"/>	NO <input type="checkbox"/>

<div style="border: 1px solid black; padding: 10px; text-align: center;"> PHOTO (MUG SHOT) PASSPORT SIZE </div>	THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO: <u>Celia M. Acosta</u> (NAME OF APPLICANT)
	RESULT: FIT <input checked="" type="checkbox"/> UNFIT <input type="checkbox"/> <div style="text-align: center;">  <u>Juan Dela Cruz</u> Name and Signature of Examining/Authorized Physician Date of Examination: <u>17/01/2019</u> </div>
OFFICIAL STAMP	Approved by: <u>prathan Dela Cruz</u> Medical Director
I HAVE READ AND UNDERSTOOD THE CONTENTS OF THE ABOVE AND THE INTEGRAL NOTES HEREOF. APPLICANT'S NAME AND SIGNATURE: <u>Celia M. Acosta</u> DATE: _____ (THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)	
DATE OF ISSUANCE OF PEME CERTIFICATE: DAY MONTH YEAR	DATE OF EXPIRATION OF PEME CERTIFICATE: (Filling out this field is not mandatory.) DAY MONTH YEAR