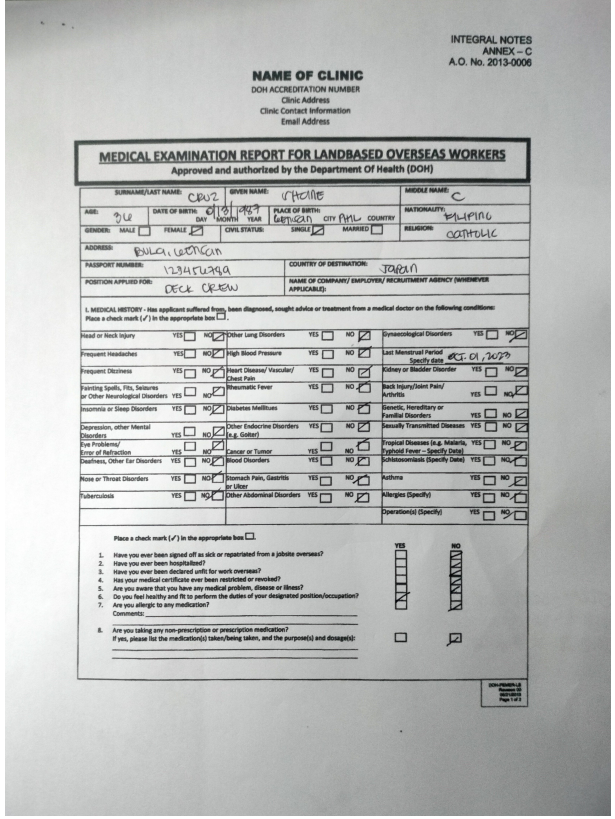

INTEGRAL NOTES
ANNEX – C
A.O. No. 2013-0006

NAME OF CLINIC
DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS
Approved and authorized by the Department Of Health (DOH)

SURNAME/LAST NAME: CRUZ | GIVEN NAME: RACHELE | MIDDLE NAME: C
AGE: 36 | DATE OF BIRTH: DAY 13 MONTH 10 YEAR 1987 | PLACE OF BIRTH: GENSAN CITY PHIL COUNTRY | NATIONALITY: FILIPINO
GENDER: MALE ☐ FEMALE ☒ | CIVIL STATUS: SINGLE ☒ MARRIED ☐ | RELIGION: CATHOLIC
ADDRESS: BULA, LEBAK
PASSPORT NUMBER: 123456789 | COUNTRY OF DESTINATION: JAPAN
POSITION APPLIED FOR: DECK CREW | NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE):

I. MEDICAL HISTORY - Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions: Place a check mark (✓) in the appropriate box ☐.

Head or Neck Injury	YES ☐	NO ☒	Other Lung Disorders	YES ☐	NO ☒	Gynaecological Disorders	YES ☐	NO ☒
Frequent Headaches	YES ☐	NO ☒	High Blood Pressure	YES ☐	NO ☒	Last Menstrual Period Specify date	OCT. 01, 2023	
Frequent Dizziness	YES ☐	NO ☒	Heart Disease/ Vascular/ Chest Pain	YES ☐	NO ☒	Kidney or Bladder Disorder	YES ☐	NO ☒
Fainting Spells, Fits, Seizures or Other Neurological Disorders	YES ☐	NO ☒	Rheumatic Fever	YES ☐	NO ☒	Back Injury/Joint Pain/ Arthritis	YES ☐	NO ☒
Insomnia or Sleep Disorders	YES ☐	NO ☒	Diabetes Mellitues	YES ☐	NO ☒	Genetic, Hereditary or Familial Disorders	YES ☐	NO ☒
Depression, other Mental Disorders	YES ☐	NO ☒	Other Endocrine Disorders (e.g. Goiter)	YES ☐	NO ☒	Sexually Transmitted Diseases	YES ☐	NO ☒
Eye Problems/ Error of Refraction	YES ☐	NO ☒	Cancer or Tumor	YES ☐	NO ☒	Tropical Diseases (e.g. Malaria, Typhoid Fever – Specify Date)	YES ☐	NO ☒
Deafness, Other Ear Disorders	YES ☐	NO ☒	Blood Disorders	YES ☐	NO ☒	Schistosomiasis (Specify Date)	YES ☐	NO ☒
Nose or Throat Disorders	YES ☐	NO ☒	Stomach Pain, Gastritis or Ulcer	YES ☐	NO ☒	Asthma	YES ☐	NO ☒
Tuberculosis	YES ☐	NO ☒	Other Abdominal Disorders	YES ☐	NO ☒	Allergies (Specify)	YES ☐	NO ☒
						Operation(s) (Specify)	YES ☐	NO ☒

Place a check mark (✓) in the appropriate box ☐.

		YES	NO
1.	Have you ever been signed off as sick or repatriated from a jobsite overseas?	☐	☒
2.	Have you ever been hospitalized?	☐	☒
3.	Have you ever been declared unfit for work overseas?	☐	☒
4.	Has your medical certificate ever been restricted or revoked?	☐	☒
5.	Are you aware that you have any medical problem, disease or illness?	☐	☒
6.	Do you feel healthy and fit to perform the duties of your designated position/occupation?	☐	☒
7.	Are you allergic to any medication? Comments: _____	☐	☒
8.	Are you taking any non-prescription or prescription medication? If yes, please list the medication(s) taken/being taken, and the purpose(s) and dosage(s): _____	☐	☒

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Reserves 00
06/21/2013
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INTEGRAL NOTES
ANNEX C
A.O. No. 2013-0006
NAME OF CLINIC
DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address
MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS
Approved and authorized by the Department Of Health (DOH)
SURNAME/LAST NAME:
GIVEN NAME:
MIDDLE NAME:
CRUZ
SHONE
C
AGE:
DATE OF BIRTH:
10/13/1987
PLACE OF BIRTH:
NATIONALITY:
36
DAY
MONTH
YEAR
GEnsan
CITY
PHIL
COUNTRY
HUPING
GENDER:
MALE
FEMALE
CIVIL STATUS:
SINGLE
MARRIED
RELIGION
CATHOLIC
ADDRESS:
BULa, wencan
PASSPORT NUMBER:
COUNTRY OF DESTINATION:
123454789
Japan
POSITION APPLIED FOR:
NAME OF COMPANY/EMPLOYER/RECRUITMENTAGENCY (WHENEVER
DECK CREW
APPLICABLE):
1. MEDICAL HISTORY Has applicant suffered from, been diagnosed, sought
advice or treatment from a medical doctor on the following conditions:
Place a check mark () in the appropriate box
.
Head or Neck Injury
YES
NO
Other Lung Disorders
YES
NO
Gynaecological Disorders
YES
NO
Frequent Headaches
YES
NO
High Blood Pressure
YES
NO
Last Menstrual Period
Specify date
OCT.01,2023
Frequent Dizziness
YES
NO
Heart Disease/Vascular/
YES
NO
Kidney or Bladder Disorder
YES
NO
Chest Pain
Fainting Spells, Fits, Seizures
Rheumatic Fever
YES
NO
Back Injury/Joint Pain/
or Other Neurological Disorders YES
NO
Arthritis
YES
NO,
Insomnia or Sleep Disorders
YES
NO
Diabetes Mellitues
YES
NO
Genetic, Hereditary or
Familial Disorders
YES
NO
Depression, other Mental
Other Endocrine Disorders
YES
NO
Sexually Transmitted Diseases
YES
NO
Disorders
YES
NO
(e.g. Goiter)
Eye Problems/
Tropical Diseases (e.g. Malaria, YES
NO
Error of Refraction
YES
NO
Cancer or Tumor
YES
NO
Typhoid Fever Specify Date)
Deafness, Other Ear Disorders
YES
NO
Blood Disorders
YES
NO
Schistosomiasis (Specify Date) YES
NO.
Nose or Throat Disorders
YES
NO
Stomach Pain, Gastritis
YES
NO
Asthma
YES
NO
or Ulcer
Tuberculosis
YES
NO
Other Abdominal Disorders
YES
NO
Allergies (Specify)
YES
NO
Operation(s) (Specify)
YES
NO
Place a check mark () in the appropriate box
YES
NO
1.
Have you ever been signed off as sick or repatriated from a jobsite
overseas?
2.
Have you ever been hospitalized?
3.
Have you ever been declared unfit for work overseas?
4.
Has your medical certificate ever been restricted or revoked?
5.
Are you aware that you have any medical problem, disease or illness?
6.
Do you feel healthy and fit to perform the duties of your designated
position/occupation?
7.
Are you allergic to any medication?
Comments:
8.
Are you taking any non-prescription or prescription medication?
If yes, please list the medication(s) taken/being taken, and the
purpose(s) and dosage(s):
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06/21/2013
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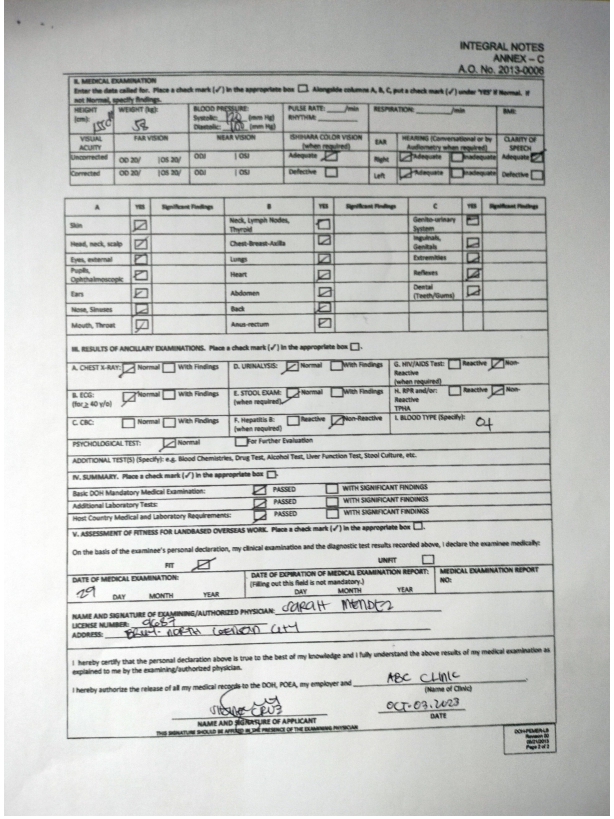

INTEGRAL NOTES
ANNEX – C
A.O. No. 2013-0006

II. MEDICAL EXAMINATION
Enter the date called for. Place a check mark (✓) in the appropriate box ☐. Alongside columns A, B, C, put a check mark (✓) under 'YES' if Normal. If not Normal, specify findings.

HEIGHT (cm): 155	WEIGHT (kg): 58	BLOOD PRESSURE: Systolic: 120 (mm Hg) Diastolic: 100 (mm Hg)	PULSE RATE: ____/min RHYTHM: ____	RESPIRATION: ____/min	BMI:
VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION (when required)	EAR	HEARING (Conversational or by Audiometry when required)	CLARITY OF SPEECH
Uncorrected	OD 20/ OS 20/	OD| OS|	Adequate ☑	Right	☑ Adequate ☐ Inadequate	Adequate ☑
Corrected	OD 20/ OS 20/	OD| OS|	Defective ☐	Left	☑ Adequate ☐ Inadequate	Defective ☐

A	YES	Significant Findings	B	YES	Significant Findings	C	YES	Significant Findings
Skin	☑		Neck, Lymph Nodes, Thyroid	☐		Genito-urinary System	☑	
Head, neck, scalp	☑		Chest-Breast-Axilla	☑		Inguinals, Genitals	☑	
Eyes, external	☑		Lungs	☑		Extremities	☑	
Pupils, Ophthalmoscopic	☑		Heart	☑		Reflexes	☑	
Ears	☑		Abdomen	☑		Dental (Teeth/Gums)	☑	
Nose, Sinuses	☑		Back	☑				
Mouth, Throat	☑		Anus-rectum	☑				

III. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (✓) in the appropriate box ☐.

A. CHEST X-RAY: ☑ Normal ☐ With Findings	D. URINALYSIS: ☑ Normal ☐ With Findings	G. HIV/AIDS Test: ☐ Reactive ☑ Non-Reactive (when required)	
B. ECG: (for ≥ 40 y/o) ☑ Normal ☐ With Findings	E. STOOL EXAM: (when required) ☑ Normal ☐ With Findings	H. RPR and/or: ☐ Reactive ☑ Non-Reactive TPHA	
C. CBC: ☐ Normal ☐ With Findings	F. Hepatitis B: (when required) ☐ Reactive ☑ Non-Reactive	I. BLOOD TYPE (Specify): O+	
PSYCHOLOGICAL TEST: ☑ Normal ☐ For Further Evaluation			

ADDITIONAL TEST(S) (Specify): e.g. Blood Chemistries, Drug Test, Alcohol Test, Liver Function Test, Stool Culture, etc.

IV. SUMMARY. Place a check mark (✓) in the appropriate box ☐.

Basic DOH Mandatory Medical Examination:	☑ PASSED	☐ WITH SIGNIFICANT FINDINGS
Additional Laboratory Tests:	☑ PASSED	☐ WITH SIGNIFICANT FINDINGS
Host Country Medical and Laboratory Requirements:	☑ PASSED	☐ WITH SIGNIFICANT FINDINGS

V. ASSESSMENT OF FITNESS FOR LANDBASED OVERSEAS WORK. Place a check mark (✓) in the appropriate box ☐.

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically:

FIT ☑ UNFIT ☐

DATE OF MEDICAL EXAMINATION:	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: (Filling out this field is not mandatory.)	MEDICAL EXAMINATION REPORT NO:
29 DAY	DAY	
MONTH	MONTH	
YEAR	YEAR	

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: SARAH MENDEZ
LICENSE NUMBER: 9687
ADDRESS: BRUM. NORTH GREENWOOD CITY

I hereby certify that the personal declaration above is true to the best of my knowledge and I fully understand the above results of my medical examination as explained to me by the examining/authorized physician.

I hereby authorize the release of all my medical records to the DOH, POEA, my employer and ABC CLINIC (Name of Clinic)

JEROME CRUZ
NAME AND SIGNATURE OF APPLICANT
THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

OCT-03-2023
DATE

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INTEGRAL NOTES
ANNEX - C
A.O. No. 2013-0006
IL MEDICAL EXAMINATION
Enter the date called for. Place a check mark () in the appropriate box
Alengside columns A, & c put a check mark () under YES W Normal, If
not Normal, specify findings.
HEIGHT
WEIGHT (kg):
BLOOD PRESSURE:
PULSE RATE:
/min
RESPIRATION
/min
BMI:
(cm):
1550m
58
Systolic 120 (mm Hg)
RNYTHM:
Diastolic
100
(mm Hg)
VISUAL
FAR VISION
NEAR VISION
ISHINARA COLOR VISION
EAR
HEARING (Convensational or by
CLARITY OF
ACUITY
(when required)
Audiometry when required)
SPEECH
Uncorrected
105 20/
ODJ
OSI
Adequate
OD 20/
Right
Adequate
Inadequate
Adequate
Corrected
OD 20/
(05 20/
ODJ
OSI
Defective
Left
Adequate
inadequate
Defective
A
YES
Significant Findings
B
YES
Significant Findings
c
YES
Significant Flowings
Neck, Lymph Nodes,
Genito-urinary
Skin
Thyroid
System
Inguinais,
Head, neck, scalp
Chest-Breast-Axilla
Genitais
Eyes, external
Lungs
Extremities
Pupils,
Heart
Reflexes
Ophthalmoscopic
Dental
Ears
Abdomen
(Teeth/Gums)
Nose, Sinuses
Back
Mouth, Throat
Anus-rectum
III. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark () in the
appropriate box
A. CHEST X-RAY:
Normal
With Findings
D. URINALYSIS:
Normal
With Findings
G. HIV/AIDS Test:
Reactive
Non-
Reactive
(when required)
B. ECG:
Normal
With Findings
E. STOOL EXAM:
Normal
With Findings
H. RPR and/or:
Reactive
Non-
Reactive
(when required)
(for_ 40 y/o)
TPHA
C CBC:
Normal
With Findings
F. Hepatitis B:
Reactive
Non-Reactive
1. BLOOD TYPE (Specify):
(when required)
of
PSYCHOLOGICAL TEST:
Normal
For Further Evaluation
ADDITIONAL TEST(S) (Specify): es Blood Chemistries, Drug Test, Alcohol
Test, Liver Function Test, Stool Culture, etc.
IV. SUMMARY. Place a check mark () in the appropriate box
Basic DOH Mandatory Medical Examination:
PASSED
WITH SIGNIFICANT FINDINGS
Additional Laboratory Tests:
PASSED
WITH SIGNIFICANT FINDINGS
PASSED
WITH SIGNIFICANT FINDINGS
Host Country Medical and Laboratory Requirements:
V. ASSESSMENT OF FITNESS FOR LANDBASED OVERSEAS WORK. Place a check mark
() in the appropriate box
On the basis of the examinee's personal declaration, my clinical
examination and the diagnostic test results recorded above, 1 declare the
examinee medically:
UNFIT
FIT
DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT:
MEDICAL EXAMINATION REPORT
DATE OF MEDICAL EXAMINATION:
(Filling out this field is not mandatory.)
NO:
29
DAY
MONTH
YEAR
DAY
MONTH
YEAR
NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: SaRaH MENDEZ
LICENSE
NUMBER:
BRUM NORTH City
9687
ADDRESS:
I hereby certify that the personal declaration above is true to the best
of my knowledge and I fully understand the above results of my medical
examination as
explained to me by the examining/authorized physician.
ABC CLINIC
I hereby authorize the release of all my medical records to the DOH,
POEA, my employer and
(Name of Clinic)
OCT_03.2023
DATE
NAME AND SIGNATURE OF APPLICANT
THIS SIGNATURE SHOULD BE AFRICIO X PRESENCE OF THE EXAMINING PHYSICIAN
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