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:
Liam	Apple	Lopez

AGE:	DATE OF BIRTH: 18 / 03 / 1991 (DAY / MONTH / YEAR)	PLACE OF BIRTH: Bacoor (CITY) Philippines (COUNTRY)	NATIONALITY:
32			Filipino

GENDER: MALE ☐ FEMALE ☑	CIVIL STATUS: SINGLE ☐ MARRIED ☑	RELIGION:
		Born Again

ADDRESS: 38 St. Michael Northgate Subd. Molino IV Bacoor City Cavite

PASSPORT NUMBER:	COUNTRY OF DESTINATION:
EB675339	Japan

POSITION APPLIED FOR:	NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE):
Technician	Amkor

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 22/09/2023		
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: Bspirin, Maxan, Mmorphin		
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):	☐	☑

II. MEDICAL EXAMINATION
Enter the data 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): 165	WEIGHT (kg): 70	BLOOD PRESSURE: Systolic: 70 (mm Hg) Diastolic: 180 (mm Hg)	PULSE RATE: 70 /min RHYTHM: Regular	RESPIRATION: 20 /min	BMI: 20

VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION (when required)	EAR	HEARING (Conversational or by Audiometry when required)		CLARITY OF SPEECH
Uncorrected	OD 20/40 | OS 20/30	ODJ 40/20 | OSJ 20/20	Adequate ☑	Right	☑ Adequate	☐ Inadequate	Adequate ☑
Corrected	OD 20/40 | OS 20/20	ODJ 20/20 | OSJ 20/20	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: TPHA ☑ Reactive ☐ Non-Reactive
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. Liver function test

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: 12 / 10 / 2023 (DAY / MONTH / YEAR)	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: (Filling out this field is not mandatory.) 12 / 10 / 2024 (DAY / MONTH / YEAR)	MEDICAL EXAMINATION REPORT NO: 487

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: Dr. Olivia Rodriguez
LICENSE NUMBER: 0278773
ADDRESS: 8B St. Nicolas Mahang Zapote Rd. Las Piñas 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 Clinic I (Name of Clinic).

Apple L. Liam
NAME AND SIGNATURE OF APPLICANT
THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

12/10/2023
DATE