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:
Peralta	Caitlin	Hale

AGE:	DATE OF BIRTH: DAY / MONTH / YEAR	PLACE OF BIRTH: CITY / COUNTRY	NATIONALITY:
33	30 / 10 / 1990	Bulacan Philippines	Filipino

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

ADDRESS:	
998 Anywhere St. Brgy. 187 Bulacan City	

PASSPORT NUMBER:	COUNTRY OF DESTINATION:
P8773311	Indonesia

POSITION APPLIED FOR:	NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE):
Welder	Cymbal

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 10 / 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) Seafood	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):	☐	☑

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):	WEIGHT (kg):	BLOOD PRESSURE:	PULSE RATE: /min	RESPIRATION: /min	BMI:
162	45	Systolic: 120 (mm Hg) Diastolic: 80 (mm Hg)	RHYTHM: Regular	16 /min	18.5

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 20/10	ODJ 20/20 | OSJ 20/30	Adequate ☑	Right	☑ Adequate	☐ Inadequate	Adequate ☑
Corrected	OD 20/20 | OS 20/40	ODJ 40/30 | OSJ 30/30	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	☐	Head injury	Chest-Breast-Axilla	☐	Broken Hearted	Inguinals, Genitals	☑	
Eyes, external	☑		Lungs	☑		Extremities	☑	
Pupils, Ophthalmoscopic	☑		Heart	☑		Reflexes	☑	
Ears	☐	dirty ears	Abdomen	☑		Dental (Teeth/Gums)	☑	
Nose, Sinuses	☑		Back	☐	scrap			
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): B+

PSYCHOLOGICAL TEST: ☑ Normal ☐ For Further Evaluation

ADDITIONAL TEST(S) (Specify): e.g. Blood Chemistries, Drug Test, Alcohol Test, Liver Function Test, Stool Culture, etc. Drug 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:	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT:	MEDICAL EXAMINATION REPORT NO:
12 (DAY) 10 (MONTH) 2023 (YEAR)	(Filling out this field is not mandatory.) 12 (DAY) / 10 (MONTH) / 2024 (YEAR)	998

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: Dr. Divina Karen
LICENSE NUMBER: 173616
ADDRESS: MB Anywhere St. Mabang 2 post Road Las Pinas 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 Hi-Precision (Name of Clinic).

Caitlin N. Peralta
NAME AND SIGNATURE OF APPLICANT
THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

12/10/2023
DATE