



UNIVERSITY HEALTH SERVICE

University of the Philippines Los Baños
College, Laguna, Philippines 4031
Tel. Nos. (049) 538-2470; 536-3247; 536-6236; 536-7566
E-mail: uhs_uplb@yahoo.com



Philhealth Accredited Health Care Provider

MEDICAL CERTIFICATE

(For Employment / Annual Medical Examination / Others)

NOV 19 2019

Date

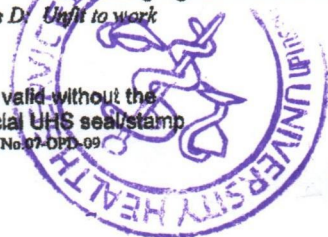
This is to certify that Mr. / Ms. Edilberto L. Gonzaga, Jr. has today been seen and examined in this hospital and has been found to be physically fit unfit to work on permanent / temporary status.

Physical Fitness Class B *

Remarks: Employable but w/ correctible defects

- * Class A: Physically fit for any work
Class B: Employable but with correctible defects
Class C: Employable but with certain limitations
and needing regular medication/check-up
Class D: Unfit to work

Not valid without the
official UHS seal/stamp
Form No. 07-DPD-09



NOV 19 2019

Examining Physician:

[Signature]
Signature above Printed Name
License No. 11342

Noted:

JESSIE MELDA F. WALDE
Director

Director



UNIVERSITY HEALTH SERVICE
University of the Philippines Los Baños, College, Laguna
Tel. Nos.: (049) 536-2470, 536-3247 local 111



LABORATORY

EDILBERTO LABIAN GONZAGA JR.

39y 1m 9d / M / Married

Date / Time: 11-Oct-2019

04:34 PM

Date of Birth: 02-Sep-1980

UP Student

Medical Exam

Case No.:

HEMATOLOGY - Adult Male (≥ 18 y/o)

Method : Celltac Es Nihon Kohden MEK-7300K

Specimen : Whole Blood

TEST	REFERENCE VALUE	RESULT	TEST	REFERENCE VALUE	RESULT
RBC : Red cell count	4.5 - 6.2 x 10 ¹² /L	5.47	Platelets:		
Hemoglobin	13 - 18 g/dL	15.9	Platelet Count	170 - 400 x 10 ⁹ /L	196
Hematocrit	40 - 50 %	47.6	MPV	6 - 11 fL	4.0
MCV	80 - 100 fL	87.0	PDW	11 - 18 %	18.7
MCH	27 - 32 pg	29.1	PCT	0.15 - 0.50 %	0.08
MCHC	32 - 36 g/dL	33.4	ABO-Rh Typing		
RDW-CV	11.0 - 16.0 %	12.3	Bleeding Time	1 - 5 mins	
WBC : White cell count	4.0 - 10.0 x 10 ⁹ /L	8.3	Clotting Time	2 - 6 mins	
Differential Count : Neutrophils	55 - 65 %	56.4	ESR	0 - 10 mm/hr	
Lymphocytes	25 - 35 %	39.3	Malarial Smear		
Monocytes	3 - 6 %	4.3			
Eosinophils	2 - 4 %				
Basophils	0 - 1 %				
Stab / Band	0 - 3 %				

***Rechecked and verified**

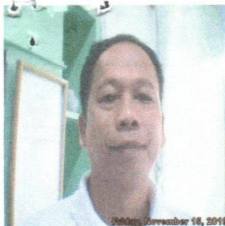
Reference values are based on WHO values adopted by the PCQACL's Standardization and Harmonization of Complete Blood Count in the Philippines 2012.

IMELDA MFP PALACOL, MD, FPSP(AP-CP) Lic.# 0080292
Pathologist

JANE CECILIA PAGUIRRE, RMT Lic # 37835
Medical Technologist

FT4812
Payment Type

IY



RQ910980
61

DEPARTMENT OF HEALTH
LOS BAÑOS BIO-SCAN CLINLAB AND MEDICAL CLINIC
 AGAPITA COMPLEX, LOPEZ AVE., BATONG MALAKE, LOS BANOS, LAGUNA

Phone Number (049) 536-4875

DRUG TEST REPORT

CCF No: 201911150003
 Name: GONZAGA, EDILBERTO JR LABIAN
 Birthdate: 02/09/1980 Age: 39 Gender: M

Transaction Date Time: 11/15/2019 11:25:00AM
 Report Date Time: 11/15/2019 1:43:33PM

Test Method TEST KIT

Purpose
 Others

Requesting Parties

Result

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	PASSED
TETRAHYDROCANNABINOL	NEGATIVE	PASSED

Test Conducted By

67 KRISTINE ZARAH LAPIZ BAUAN

Analyst

Approved By

DR. ALEXTER A. LEDESMA

Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report



Los Baños BioScan Clinlab & Medical Clinic

AGAPITA COMPLEX, LOPEZ AVE., BATONG MALAKE, LOS BAÑOS, LAGUNA
TEL/FAX NO: (049) 536-4875
EMAIL ADD: lb_bioscanclinlab@yahoo.com.ph

CUSTODY AND CONTROL FORM (Form DT-002A - COPY FOR THE DONOR)

SPECIMEN ID NO.:

LAB ACCESSION NO.:

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

✓ Client's/Donor's/Subject's Name: <u>Edilberto L. Gonzaga, Jr.</u>		B. Address: <u>Visca, Baybay City, Leyte</u>		Age: <u>39</u>		D. Sex: <u>M</u>	
✓ E. Employer Name and Address: <u>Visayas State University, Visca, Baybay City, Leyte</u>							
F. Type of Specimen		G. Reason for Test:					
<input checked="" type="checkbox"/> Urine		<input checked="" type="checkbox"/> Pre-employment		<input type="checkbox"/> Random		<input type="checkbox"/> Reasonable Suspicion/Cause	
<input type="checkbox"/> Blood		<input type="checkbox"/> Return-to-Duty		<input type="checkbox"/> Mandatory		<input type="checkbox"/> Post-accident	
<input type="checkbox"/> Others (specify) _____		<input type="checkbox"/> Follow-up		<input type="checkbox"/> Follow-up		<input checked="" type="checkbox"/> Others (specify) <u>promotion</u>	
H. Drug test to be Performed:		<input type="checkbox"/> THC, COC, PCP, OPI, AMP		<input checked="" type="checkbox"/> THC & MET Only		<input type="checkbox"/> Others (specify) _____	

STEP 2 COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes.	Specimen Collection: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved	Other Observation (Enter Remark)
Is temperature between 32°C and 38°C?	Specimen Sampling: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Volume: <u>10</u> ml Physical Appearance: Color: <u>yellow</u>	
REMARKS		

STEP 3 Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initial seal(s). Donor completes STEP 5.

STEP 4 CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Step 5 of this form was collected, sealed and released to the Delivery Service noted in accordance with applicable Department of Health requirements.		SPECIMEN BOTTLE (S) RELEASED TO:	
X	Signature of Collector	Time of Collection	AM/PM
	<u>LYN P. ABASOLO</u>	<u>11, 15, 19</u>	<u>AM</u>
(PRINT) Collector's Name (First, MI, Last)		Name of delivery Service Transferring Specimen to Lab.	
RECEIVED AT LAB.:		STATUS OF THE SPECIMEN	
X	Signature of Accessioner	(a) Seal intact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<u>HAZEL R. MACAPINLAC</u>	(b) Transport device:	
(PRINT) Accessioner's Name (First, MI, Last)		© Description:	
<u>11, 15, 19</u>		Date (mm/dd/yy)	
		SPECIMEN BOTTLE (S) RELEASED TO:	
		Signature of Receiving Person	
		(PRINT) Name (First, MI, Last)	
		Date (mm/dd/yy)	

STEP 5 COMPLETED BY THE DONOR

I certify that I provided my urine specimen to the collector, that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information on this form and on the bottle is correct.		✓ <u>EDILBERTO L. GONZAGA, JR.</u>		✓ <u>11, 15, 19</u>	
Signature of Donor		(PRINT) Donor's Name (First, MI, Last)		Date (mm/dd/yy)	
✓ Contact No.: <u>09168860048</u>		✓ Date of Birth: <u>02/09/80</u>		(mm/dd/yy)	
Additional information may be asked from you by the laboratory particularly on drug and medications.					

STEP 6 COMPLETED BY HEAD/OF SCREENING LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification is:		REFUSAL TO TEST BECAUSE	
<input checked="" type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> TEST CANCELLED		<input type="checkbox"/> DILUTED <input type="checkbox"/> SUBSTITUTED	
REMARKS: <u>Kristine Zarab, Banao, RMT</u>		<input type="checkbox"/> ADULTERATED <input type="checkbox"/> Others (specify) _____	
X	Signature of Analyst	Signature of Head of Laboratory	
	<u>Lic. No. 0064471</u>	<u>11, 15, 19</u>	
(PRINT) Signature & Name of Analyst (First, MI, Last)		(PRINT) Signature & Name of Head of Laboratory (First, MI, Last)	
		Date (mm/dd/yy)	

STEP 7 COMPLETED BY CONFIRMATORY LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:		FAILED TO CONFIRM - REASON: _____	
<input type="checkbox"/> CONFIRMED FOR:		<input type="checkbox"/> FAILED TO CONFIRM - REASON: _____	
<input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> Others (specify) _____			
X	Signature of Analyst	Signature of Head of Laboratory	
	<u>11, 15, 19</u>	Date (mm/dd/yy)	
(PRINT) Signature & Name of Analyst (First, MI, Last)		(PRINT) Signature & Name of Head of Laboratory (First, MI, Last)	

STEP 8 TO BE COMPLETED BY THE NATIONAL REFERENCE LABORATORY (NRL)

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:		FAILED TO RECONFIRM - REASON: _____	
<input type="checkbox"/> RECONFIRMED FOR:		<input type="checkbox"/> FAILED TO RECONFIRM - REASON: _____	
<input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> Others (specify) _____			
X	Signature of Analyst	Signature of Head of Laboratory	
	<u>11, 15, 19</u>	Date (mm/dd/yy)	
(PRINT) Signature & Name of Analyst (First, MI, Last)		(PRINT) Signature & Name of Head of Laboratory (First, MI, Last)	

1. Form DT-002A-Copy for the Donor
2. Form DT-002B-Copy for the Collection Site
3. Form DT-002C-Copy for the Laboratory
4. Form DT-002D-Copy for the Confirmatory Laboratory (For Positive Sample)