

MEDICAL CERTIFICATE

(For Employment)

INSTRUCTIONS

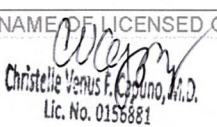
- This medical certificate should be accomplished by a licensed government physician.
- Attach this certificate to original appointment, transfer and reemployment.
- The results of the following pre-employment medical/physical/psychological must be attached to this form:

- ☒ Blood Test
- ☒ Urinalysis
- ☒ Chest X-Ray
- ☒ Drug Test
- ☐ Psychological Test
- ☒ Neuro-Psychiatric Examination (if applicable)

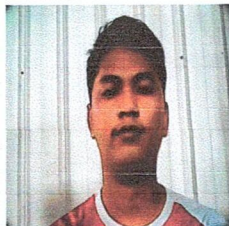
FOR THE PROPOSED APPOINTEE

NAME (Last Name, First Name, Name Extension (if any) and Middle Name)			AGENCY / ADDRESS
MODINA, AJUN, DACULA			DFS, VSU
ADDRESS			
PANGASUGAN BAYBAY, LEYTE			
AGE	SEX	CIVIL STATUS	PROPOSED POSITION
24	M	S	TRUCK / CHAINSAW OPER...

FOR THE LICENSED GOVERNMENT PHYSICIAN

I hereby certify that I have reviewed and evaluated the attached examination results, personally examined the above named individual and found him/her to be physically and medically <input checked="" type="checkbox"/> FIT / <input type="checkbox"/> UNFIT for employment.			
SIGNATURE over PRINTED NAME OF LICENSED GOVERNMENT PHYSICIAN:		OTHER INFORMATION ABOUT THE PROPOSED APPOINTEE	
 Christelle Venus F. Capuno, M.D. Lic. No. 0156881			
AGENCY/Affiliation of Licensed Government Physician:			
VSU Hospital			
LICENSE NO.	HEIGHT (M) Bare Foot	WEIGHT (KG) Stripped	BLOOD TYPE
0156881	164	69	0
OFFICIAL DESIGNATION	DATE EXAMINED		
Medical Officer III	11-8-24		

DP
10/70



QL000100

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DEPARTMENT OF HEALTH
DIVINE RAYS DIAGNOSTIC AND MEDICAL SUPPLIES
LILIA AVENUE, COGON COMBADO, ORMOC CITY, LEYTE

Phone Number 09179069427

DRUG TEST REPORT

CCF No: 202411060022

Transaction Date Time: 11/6/2024 4:13:00PM

Name: MODINA, ALJUN DACULA

Report Date Time: 11/6/2024 4:24:22PM

Birthdate: 11/01/2000

Age: 24

Gender: M

Test Method TEST KIT

Purpose

Government Employment

Requesting Parties

VSU

Result

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	PASSED
TETRAHYDROCANNABINOL	NEGATIVE	PASSED

Test Conducted By

Approved By

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JEFFREY MENDOZA SANCHEZ

Analyst

DR. JENNIFER S. COUSIN ABIERAS

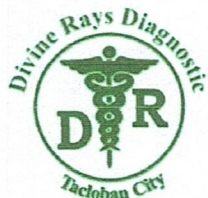
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Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

X-RAY* ULTRASOUND* ECG* LABORATORY* DRUG TEST* MEDICAL CLINIC* MEDICAL MOBILE SERVICE



DIVINE RAYS DIAGNOSTIC & MEDICAL SUPPLIES

DR Bldg., Avenida Veteranos Street,
Tacloban City, 6500 Leyte Philippines
Tel# 053 523 1138

Date: 11-06-2024

Last Name			FIRST NAME	M.I.	Intended Occupation
MODINA			ALJUN	D	
CIVIL STATUS	AGE	SEX	ADDRESS		
SINGLE	24	MALE	BAYBAY CITY, LEYTE		
EDUCATIONAL ATTAINMENT: HIGH SCHOOL GRADUATE					
PURPOSE OF EXAMINATION: EMPLOYMENT					
Tests Administered:					
Personality Test		GPP test	Others	Autobiography/Interview	

Personality Test Group

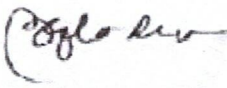
I. Personality Traits and Characteristic	1	2	3	4
Ascendancy (A)				
• Active role in group	X			
• Self-Assured & Assertive	X			
• Makes independent decisions	X			
Responsibility (R)				
• Stick to job assigned to them		X		
• Persevering & determined		X		
• Can be relied upon		X		
Emotional Stability (E)				
• Well balanced individual	X			
• Emotionally stable	X			
• Tolerance to stress	X			
• Relaxed	X			
Sociability (S)				
• Likes to be & work with people	X			
• Gregarious and sociable	X			


II. Conclusions/ Remarks

X	Recommended with no significant manifestation of personality disturbance noted at the time of evaluation
	Recommended with reservation for further evaluation

Note: Descriptive rating

- 1 High Average
- 2 Average
- 3 Below Average
- 4 Low


ZAIDA Q. LADRERA
Test Administrator


MARIFE T. BERCASIO, RPh
Psychometrician
PRC NO. 0012077

DIVINE RAYS DIAGNOSTIC & MEDICAL SUPPLIES

Lilia Avenue, Brgy. Cogon, Ormoc City

Contact No: 0977 268 7287

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

SPECIMEN NO. _____

LAB ACCESSION NO. _____

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Client's/Donor's/Subject's Name <u>ALVIN D. MODINA</u>		B. Address <u>PANGA SUBAN BAYBAY</u>		C. Age <u>24</u> Y. Sex <u>M</u>
D. Employer Name and Address <u>VSU BAYBAY CITY, LEYTE</u>				
F. Type of Specimen: <input checked="" type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Other's (Specify) _____		G. Reason for Test <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicious/Cause <input type="checkbox"/> Return to Duty <input type="checkbox"/> Mandatory <input type="checkbox"/> Post Accident <input type="checkbox"/> Follow-Up <input type="checkbox"/> Other's (Specify) _____		
H. Drug Test to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input checked="" type="checkbox"/> THC & MET ONLY <input type="checkbox"/> Other's (Specify) _____				

STEP 2: COMPLETED BY COLLECTOR

Read specimen temp. within 4 minutes. Is Temperature between 32oC and 38oC? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Collection: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved Specimen Sampling: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split Specimen Volume: <u>100</u> ml Physical Appearance: Color <u>Y</u>	Other Observation:
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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 release to the Delivery Service noted in accordance with applicable Department of Health requirements.	SPECIMEN BOTTLE(S) RELEASED TO:
Signature of Collector _____ Time of Collection <u>4:00</u> AM/PM <u>11-06-24</u>	Name of Delivery Service Transferring Specimen to Laboratory _____
(PRINT) COLLECTOR'S NAME _____ DATE (Mo/Day/Year) _____	

RECEIVED AT LAB: Signature of Accessioner _____ (PRINT) ACCESSIONER'S NAME _____ DATE (Mo/Day/year) _____	Status of the Specimen A) Seal Intact <input type="checkbox"/> Yes <input type="checkbox"/> No B) Transport device _____ C) Description _____	SPECIMEN BOTTLE(S) RELEASED TO: Signature of RECEIVING PERSON _____ PRINTED NAME _____ Date _____
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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 matter, each specimen bottle used was sealed with a tamper-evident seal in my presence and that the information provided on this form and on the bottle is correct.

Signature of Donor _____ Contact No. <u>09125873830</u>	(PRINT) Donor's Name (First, MI., Last) <u>ALVIN D. MODINA</u>	Date of Birth <u>11/06/24</u> <u>21</u> Mo <u>12</u> Day <u>2000</u> Year
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STEP 6: COMPLETED BY HEAD OF SCREENING LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ REFUSAL TO TEST BECAUSE:
☐ DILUTED ☐ ADULTERATED ☐ SUBSTITUTED (specify) _____

REMARKS

DR. JENNIFER DUCUSIN ABIERAS

SIGNATURE & NAME OF ANALYST _____	SIGNATURE & NAME OF HEAD OF LAB _____	DATE (Mo/Day/Year) _____
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STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

In accordance with the applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

☐ CONFIRMED FOR: ☐ CHALLENGE ☐ FAILURE TO CONFIRM-REASON _____
☐ THC ☐ MET ☐ OTHERS _____

SIGNATURE OF ANALYST _____	SIGNATURE & NAME OF HEAD OF LAB _____	DATE (Mo/Day/Year) _____
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STEP 8: TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL)

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

☐ RECONFIRMED FOR: ☐ THC ☐ MET ☐ FAILED TO CONFIRM-REASON _____
☐ OTHERS _____

SIGNATURE OF ANALYST _____	SIGNATURE & NAME OF HEAD OF LAB _____	DATE (Mo/Day/Year) _____
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