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:
AGE:	DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH: CITY COUNTRY	NATIONALITY:
GENDER: MALE ☐ FEMALE ☐	CIVIL STATUS: SINGLE ☐ MARRIED ☐		RELIGION:
ADDRESS:			
PASSPORT NUMBER:	COUNTRY OF DESTINATION:		
POSITION APPLIED FOR:	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 ☐.

Condition			Condition			Condition		
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 ________		
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 ☐.

	Question	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? ☐ YES ☐ NO
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: Systolic:________(mm Hg) Diastolic:_______(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/	ODJ | OSJ	Adequate ☐	Right	☐ Adequate ☐ Inadequate	Adequate ☐
Corrected	OD 20/ | OS 20/	ODJ | OSJ	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):

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

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN:______________________________
LICENSE NUMBER: ______________________
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.

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

______________________________ ______________________
NAME AND SIGNATURE OF APPLICANT **DATE**
THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

SPECIFICATIONS OF AND INSTRUCTIONS ON HOW TO ACCOMPLISH THE "MEDICAL EXAMINATION REPORT (MER) FOR LANDBASED OVERSEAS WORKERS"

1. Use only size A4 bond paper with a MINIMUM of substance 20.
2. Use only one (1) sheet of bond paper with the following back to back information:
   a. Front page – contains the following:
      1. Personal Information of the Applicant;
      2. Medical History.

   b. Back page – contains the following:
      1. Medical Examination;
      2. Results of Ancillary Examinations;
      3. Summary of the Medical Examination Report;
      4. Assessment of Fitness for Landbased Overseas Work Applicants.
3. Use only English language.
4. Use only black ink.
5. Use only white background.
6. The Official Stamp or Clinic Logo may be in color but the clinic name and information must be in black.
7. Security features are allowed.
8. Kindly put a check mark (✓) on the appropriate box ☐ and enter all data called for. Do not leave any item blank.
9. The applicant shall affix his signature in the presence of the examining physician.
10. The signature of the examining physician shall be original and/or in accordance with the E-Commerce Law.
11. The MER stays with the medical clinic where PEME was conducted. A principal/ employer in need of further medical information contained in the MER shall make a formal request addressed to the head of the clinic.

Approved by:

ATTY. NICOLAS B. LUTERO III, CESO III
Assistant Secretary
Department of Health

DOH-PEMER-I-LB
Revision:00
05/21/2013