	MEDICAL FITNESS CERTIFICATE MEDICAL REPORT (This document was adopted from Saipem company and used only for Saipem client/subcontractor)
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MEDICAL FITNESS CERTIFICATE

Issued in accordance with Oil & Gas UK Guidelines, Saipem Corporate Standards OPR-COR-HR-HLT-001-E, STD-COR-HILICLI-001-I, IMO and STCW Guidelines on medical examination

Full name (in block letters) MUHAMMAD FHADLY	Date of Birth 8 / 10 / 1994	Occupation ASST INSPECTOR
This Health Certificate is valid until: <u>4 / 3 / 2022</u>		
<input checked="" type="checkbox"/> Fit <input type="checkbox"/> Fit with prescriptions and/or restrictions <input type="checkbox"/> Unfit	<input checked="" type="checkbox"/> offshore <input type="checkbox"/> permanent	<input type="checkbox"/> onshore <input type="checkbox"/> temporary for months <input type="checkbox"/> permanent <input type="checkbox"/> temporary for months
Specify prescriptions and/or restrictions <div style="text-align: center; border: 2px solid red; padding: 5px; font-size: 24px; font-weight: bold; color: red; margin: 10px auto; width: 80%;"> FIT TO WORK </div>		

Applicant's signature in the Doctor's presence

Batam
Place

5 / 3 / 2021
Day, Month, Year



Komplek Taman Niaga Suka Jadi Blok J No. 3A-6 Batam
 Tel: 0778 - 7372022, 7372023 Fax: 0778 - 7372024
 Doctor's stamp and signature

dr. Rindi Nursaadah Sagala
 002.1/001-356/SIP.TM/DPMPTSP-BTM/VIII/2020

Employer must provide the personal protective equipment specific to the activity

1. PERSONAL ANAMNESIS

Name in full	MUHAMMAD FHADLY	Date of Birth	08/10/1994	Sex	<input checked="" type="radio"/> M <input type="radio"/> F
Occupation	ASST. INSPECTOR	Badge No.		Blood Group	<input type="checkbox"/> Rh <input type="checkbox"/>

Please tick box <input type="checkbox"/>		Yes	No	Details if "yes" (including dates and duration and any other relevant information)
		<input type="checkbox"/>	<input type="checkbox"/>	
1. a)	Are you at present under medical care or receiving treatment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Are you currently taking medication, prescribed or not, having injection, using an inhaler or have you recently done so, or are you on a special diet?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.	Have you ever suffered from:			
a)	Fits, fainting, giddiness or any mental or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Asthma, bronchitis, pneumonia or any other lung disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c)	Rheumatism, rheumatic fever, arthritis or any other disorder of joints and muscle?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
d)	Chest pain, shortness of breath, palpitation, high blood pressure or other disorders of the heart or circulation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
e)	Indigestion, peptic ulcer, diarrhoea, constipation or any intestinal complaint, hepatitis or other liver disorders, diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
f)	Kidney, bladder or other genito-urinary disorders?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
g)	Any injury, operation, physical defect or deformity?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
h)	Any other illness not mentioned above?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. a)	Have you ever been a patient at a hospital, nursing home or special clinic?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Have you ever had any medical investigation carried out?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4.	Have you ever had any form of sexually transmitted disease or is there anything about your lifestyle which could expose you to the risk of AIDS or AIDS related condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5.	Female only: Have you ever had any gynaecological or obstetric problems?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6.	Have you ever taken drugs other than prescribed by any doctor?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
7. a)	Non-smoker: Have you smoked in the past?	<input type="checkbox"/>	<input type="checkbox"/>	
b)	Smokers: How much do you smoke per day?	→		Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes <input type="checkbox"/> Number smoked <input checked="" type="checkbox"/>
c)	What is the average daily consumption of alcohol?	→		

2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father	56	HEALTHY		
Mother	56	HEALTHY		
Brother / Sister	25	HEALTHY		
Brother / Sister	22	HEALTHY		
Brother / Sister	20	HEALTHY		

I declare to the best of my knowledge and belief the answers to the above questions are true and complete. I confirm that I have checked and found correct any answers that are not in my handwriting. I grant permission to take samples of blood, saliva and/or urine in connection with this examination. I understand that this statement will be forwarded to the Company's Medical Department.

Applicant's Signature
(to be signed in the presence of Medical Examiner)

DATE 05/03/2024

3. SUMMARY OF MEDICAL HISTORY MR. /MRS. MUHAMMAD FHADLY

Has the applicant ever had or has now any of the following? If yes, give details in the summary description.

Please, tick box, whether normal or not	<input type="checkbox"/> Yes No		Yes No	
	Yes	No	Yes	No
1. Ear infection / Sinusitis / Vertigo	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Nose, mouth or throat trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Color blindness / Loss of vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Frequent headaches / Fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Epilepsy / Mental illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Hypertension	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Diabetes mellitus	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Endocrine disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Hernia / Hydrocele / Piles / Fissures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Fistula / Appendicitis / Varicocele	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Malaria / Tropical Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Skin disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Cancer or tumor	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Allergy to foods / drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Remarks:

4. MEDICAL EXAMINER'S REPORT

If you answer Yes to any of the following questions, please give full details with any ascertainable cause as applicable

Please tick box <input type="checkbox"/>	Yes No		Details if "yes"	
	Yes	No		
8. Measurement & Physical Description				
a) Measurements (to be taken in indoor clothing)			Height: 160 cm	Weight: 67 Kg
b) Please describe general appearance and build:			BMI: 26.17 Kg/m ²	Waist Circumference: 88 cm
c) Are there any signs of past or present over-indulgence in alcohol, tobacco, or irregular lifestyle	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Is there any enlargement of lymph nodes or thyroid gland?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Are there any scars of material significance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
9. Cardio-vascular System & Blood pressure				
a) Does the heart appear to be enlarged? If "yes", do you consider this to be slight, moderate or marked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there any irregularity of rhythm?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is there any abnormality in the arterial pulse?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Are there any varicose veins?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Blood Pressure: (please record opposite)		<input checked="" type="checkbox"/>	Systolic / Diastolic: 101 / 83	Pulse Rate: 82x/mnt
10. Respiratory System				
a) Is there any abnormality in the shape and development of the chest?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Are there any abnormal physical signs in the lungs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
11. Genito / Urinary & Digestive System				
a) Is the urine test abnormal?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there any abnormal tenderness, enlargement or other palpable abnormality in abdomen?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is a hernia present	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Is there any dental problem such as caries, recurrent gum and mouth infections, abscess etc.?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
12. Nervous System				
a) Is there any sign of disease in the central nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there anything to suggest a tendency to psychiatric disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
13. Sense Organs				
a) Is there any affection of the eyes, ears, nose or tongue	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Left Tonsil J03 T1, Right Tonsil J03 T1	
Vision			Color Vision	
Uncorrected	Far Vision	Near Vision	Adequate	<input checked="" type="checkbox"/>
OD 6/6	OS 6/6	OD J1 OS J1	Defective	
Corrected	OD - OS -	OD - OS -		

Remarks:

5. EXAMINATION RESULTS AND REPORT

X-Ray, ECG, Audiogram and Blood Urine Laboratory Examination Report

All examination results are to be attached. Please, indicate your remarks in case of abnormal results

1. Chest X-Ray Report (****) Normal Limited

2. ECG Report Normal Resting ECG

3. Audiogram Report Normal

4. Spirometry Report -

5. Blood Examination Report (Please, attach the results of the following examinations or indicate here below the results):

1) Hemoglobin	16.5 gr/dl	10) MCV (*)	19) HDL Cholesterol	54 mg/dl
2) RBC	5.25 x 10 ⁶ /mm ³	11) MCM (*)	20) LDL Cholesterol	173 mg/dl
3) ESR	5 mm/hr	12) MCHC (*)	21) Triglycerides	113 mg/dl
4) WBC	8.3 x 10 ³ /mm ³	13) Platelet	22) Total Bilirubin	0.7 mg/dl
5) Neutrophils		14) Reticulocyte (*)	23) Direct Bilirubin	0.4 mg/dl
6) Lymphocytes	28.2 %	15) Hematocrit	24) AlkalinePhosphatase	74 u/L
7) Monocytes	6.5 %	16) Glycemia	25) AST (SGOT)	35 u/L
8) Eosinophils		17) Blood Urea	26) ALT (SGPT)	48 u/L
9) Basophils		18) Total Cholesterol	27) Gamma GT	60 u/L
				250 mg/dl

6. Urine Examination Report (Physical, Chemical and Microscopy test results: Please attach the results of the following examinations or indicate here below the results). Please indicate abnormalities (if Any):pH: 5, SG: 1.015, Glucossa: (-), Protein: (-), Ketones: (-), Bilirubin: (-), Urobilinogen: (-), Nitrit: (-), Blood: (-), Leucocytes: (-)

7. Drugs (**), alcohol screening test Report (***):(Please attach the results of the following examinations or indicate here below the results):
 1) Amphetamines NEGATIVE 3) Cocaine NEGATIVE 5) Methamphetamine NEGATIVE 7) Alcohol
 2) Benzodiazepine NEGATIVE 4) Marijuana NEGATIVE 6) Opiates NEGATIVE

- 8. HIV Test (*)
- 9. Tine (Tuberculin test) (*)
- 10. HBsAg (**) (-) HBsAb (**) HBCab (**) HBeAg (**) HBeAb (**) HAVAb (**) HCVAb (**)
- 11. TPHA (-)
- 12. Stool examination (*)
- 13. Pharyngeal plug test (*)

(*)Only if required (**) Only to the personnel who have never been vaccinated before or if expressly required

(***)Compulsory on pre-employment medical examinations and periodical examination for OFFSHORE and employees involve in Safety Sensitive Positions (SSP). For all other employees depend on circumstances, national and international legal requirements.

(****) Chest X-ray is required on the first examination. Afterwards, the examining physician has the discretion whether to perform it or not, based on physical examination, laboratory results, epidemiological situation and local laws and regulation in the country of origin or assignment.

6. OVERALL SUMMARY, ASSESSMENT AND RECOMMENDATIONS

The present Medical Certificate is valid until:04-Mar-2022

I have examined Mr./Mrs. MUHAMMAD FHADLY and found him/her (tick the box)

FIT for (offshore/onshore) duty UNFIT for duty Pending

DR. **dr. Rindi Nursaadah Sagala**
Examining Doctor's Signature
(Stamp, Signature, Name and address of the Physician)

Date: 05-Mar-2021



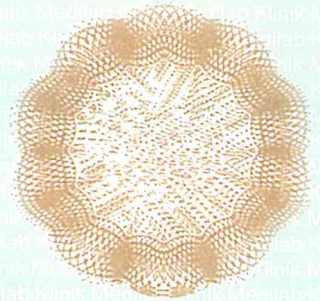
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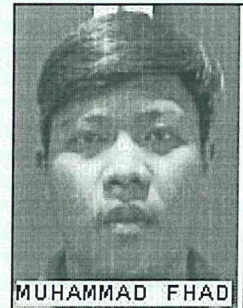
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Telp: (0778) 7372022, 7372023, 0811 770 1188, 0811 770 1199. Fax: (0778) 7372024
E-mail: customercare@medilab-clinic.com, Website: www.medilab-clinic.com



EYE EXAMINATION REPORT

IDENTIFICATION OF APPLICANT

Applicant's Name : MUHAMMAD FHADLY
DOB/Gender/Emp. ID: 8 October 1994 / Male / 19120
Address : KAV SAGUBA BLOK A NO 104, BATAM
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



MUHAMMAD FHADLY

Distant Vision Acuity (<i>Snellen Chart</i>)	
Right Eye:	6/6 Without Glasses
Left Eye :	6/6 Without Glasses

Near Vision Acuity	
Right Eye :	J1 Without Glasses
Left Eye :	J1 Without Glasses

Colour Vision (<i>Ishihara's Test</i>)	Normal
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Visual Field Test (<i>Confrontation Test</i>)	-
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Grey Test	-
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Depth Test	-
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DR. RINDI NURSA'ADAH SAGALA

Examiner's Name

Examiner's Signature

BATAM, 05 March 21

Place, Date of eye examination



Official Stamp of Medical Practitioner

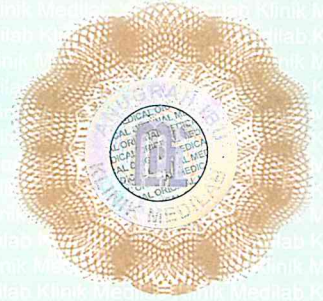


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HEALTH SCREENING REPORT

Preemployment Physical Examination

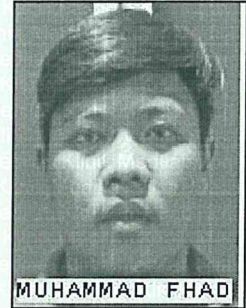
CONFIDENTIAL

No. Medical Record : 
00027/002/III/ISP/21

171

PERSONAL DATA

Name : MUHAMMAD FHADLY
 Birthday/Gender/Emp. ID : 8 October 1994 / Male / 19120
 Father's Name : YON ANISMI
 Address : KAV SAGUBA BLOK A NO 104, BATAM
 Occupation : ASST INSPECTOR
 Name of Employer / Recruitment Agency : INSPEKTINDO SINERGI PERSADA, PT
 Address of Employer / Recruitment Agency : KAWASAN INDUSTRI SEKUPANG KAVLING.13, BATAM



MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
1. Hypertension	<input type="checkbox"/>	<input checked="" type="checkbox"/>	4. Allergic Rhinitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	7. Surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Bronchial Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	5. Peptic Ulcer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8. Echolalia	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Bloody Cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>	6. Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9. Others	<input type="checkbox"/>	<input checked="" type="checkbox"/>

CLINICAL EXAMINATION

		Yes/Abnormal	No/Normal			Yes/Abnormal	No/Normal
Weight	: 67 Kg			3. Cardiovascular System			
BMI	: 26.17			a. Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
				Systolic / Diastolic	: 101 / 83 mm Hg		
1. Vision				Pulse	: 82 / min		
a. Distant Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>		b. Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
(Should be at least 6/12 in both eyes with or without glasses)				c. Varicose Veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b. Near Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>		4. Respiratory System	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
(Should be at least J2 in both eyes with or without glasses)				5. Skin-Chronic Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c. Colour Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>		6. Abdomen	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
d. Any Organic Eye Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>		7. Locomotor/Neurological	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Hearing	<input type="checkbox"/>	<input checked="" type="checkbox"/>		8. Endocrine disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
(Unable to hear ordinary conversation at 2 m)				9. Mental State	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

LABORATORY TEST

(Report Enclosed)

	Yes/Abnormal	No/Normal
1. Blood Count	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Urine Feme	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Other Laboratory Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>

OTHER TEST

(Report Enclosed)

	Yes/Abnormal	No/Normal
1. Audiometry	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Spirometry	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. ECG (if indicated)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Chest X-Ray	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Remarks: Overweight E66, E.N.T: Left Tonsil J03 T1, Right Tonsil J03 T1, Waist Circumference: 88 cm, Lab: SGPT R74.9 48 U/L MIE, GGT R74.9 60 U/L MIE, Total Cholesterol E78.0 250 mg/dl VHR, HDL E78.4 54 mg/dl BHR, LDL E78.4 173 mg/dl HR, Cholesterol Ratio E78 4.6 AR

CERTIFICATION

I certify that I have examined the abovenamed person. In my opinion, this person is FIT for duties mentioned above.

ADVICE :

Regular Exercise and Reduce Weight, Avoid Cool & Spicy Food, Take Enough Rest & Consume Curcuma, Low Fat Diet

Authentic Signature



Date of Exam : 5 March 2021



DR. RINDI NURSA'DAH SAGALA

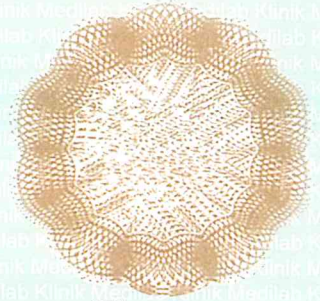


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HEALTH SCREENING REPORT

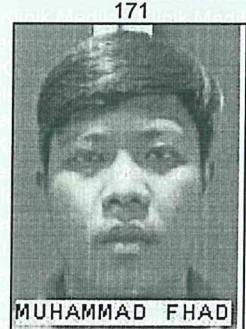
Preemployment Physical Examination

CONFIDENTIAL

No. Medical Record : 
00027/002/III/ISP/21

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LABORATORY REPORT

BLOOD COUNT

Test Name	Result Unit	Reference Range		
HGB	16.5 gr/dl	M: 13.2 - 17.3	F: 11.7 - 15.5	
WBC	8.3 10 ³ /mm ³	M: 3.8 - 10.6	F: 3.6 - 11.0	
RBC	5.25 10 ⁶ /mm ³	M: 4.4 - 5.9	F: 3.8 - 5.2	
ESR	5 mm/hr	M: 0 - 10	F: 0 - 20	
HCT	50.4 %	M: 40 - 52	F: 35 - 47	
PLT	306 10 ³ /mm ³	150 - 440		
Differential Count				
- LYM	28.2 %	25 - 40		
- MON	6.5 %	2 - 8		
- GRA	65.3 %	43 - 76		
Indicator of Infection				
- Neutrofil Lymphocyte Ratio (NLR)	2.31 %	> 3.13 Cautious	6 - 9 Suspicious	> 9 Perilous
- Absolute Lymphocyte Count (ALC)	2341 %	< 1500 Cautious	< 1100 Suspicious	< 500 Perilous

URINE FEME

Macroscopy	Result	Microscopy	Result
- pH	5	- WBC/HPF	Occ/HPF
- Specific Gravity	1.015	- RBC/HPF	Nil/HPF
- Glucosaa	Negative	- Epithel Cell	Nil
- Protein	Negative	- Crystals	Nil
- Ketones	Negative	- Cast	Nil/HPF
- Bilirubin	Negative		
- Urobilinogen	Normal		
- Nitrit	Negative		
- Blood	Negative		
- Leucocytes	Negative		

X-RAY REPORT

Chest PA:
 Show no Abnormalitis.
 There is no evidence of pulmonary tuberculosis or other pulmonary,pleural or mediastinal lesions.
 The size,shape and position of the heart are within limits of normal variations.
 Bony structures of the thorax show no abnormalities.

Date of Exam : 5 March 2021



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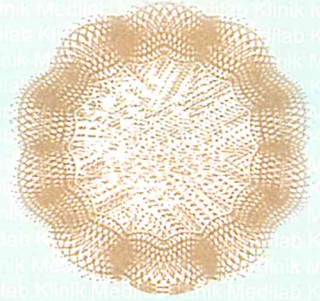


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HEALTH SCREENING REPORT

Preemployment Physical Examination

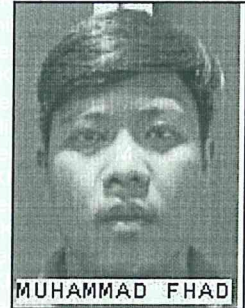
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MUHAMMAD FHADLY

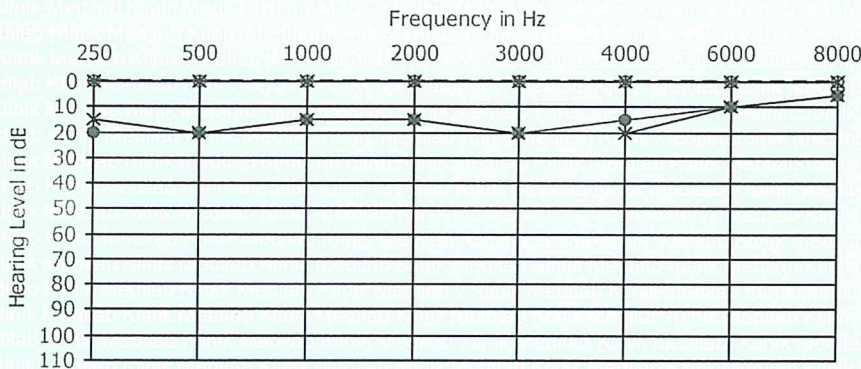
AUDIOMETRY REPORT

Occupational History

	Yes	No
- Noisy Working Environment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
- Present/use of Hearing Protector	<input checked="" type="checkbox"/>	<input type="checkbox"/>
- Period of Working	1.0 years	

Medical History/Examination

	Yes	No	If Yes, which ear	Left	Right
- Ear Surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
- Head/Ear Injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
- Ears Infection	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
- Ear Drum Perforation	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
- Ear Cerumen	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>



● REAC
 × LEAC
 ○ REBC
 × LEBC

Conclusion :

- Audiogram : Normal
- Hearing Impairment : Monaural : R : -11.25 %
L : -11.25 %
Hearing Handicap : -11.25 %
- Not a Noise Induced Hearing Loss

Date of Exam : 5 March 2021



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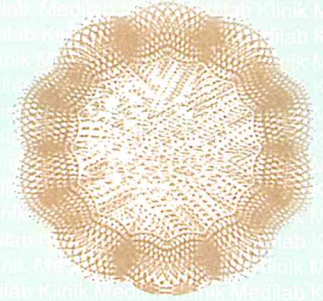


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PUSAT PEMERIKSAAN KESEHATAN TENAGA KERJA

Komplek Taman Niaga Sukajadi Blok J No. 3A-6 Jl. Ahmad Yani - Batam 29433
Telp: (0778) 7372022, 7372023, 0811 770 1188, 0811 770 1199. Fax: (0778) 7372024
E-mail: customercare@medilab-clinic.com, Website: www.medilab-clinic.com



HEALTH SCREENING REPORT

Preemployment Physical Examination

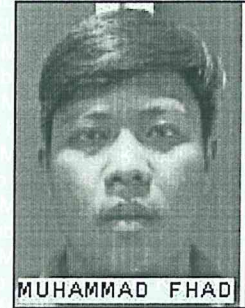
CONFIDENTIAL

No. Medical Record : 
00027/002/III/ISP/21

PERSONAL DATA

Name : MUHAMMAD FHADLY
Birthday/Gender/Emp. ID : 8 October 1994 / Male / 19120
Father's Name : YON ANISMI
Address : KAV SAGUBA BLOK A NO 104, BATAM
Occupation : ASST INSPECTOR
Name of Employer / Recruitment Agency : INSPEKTINDO SINERGI PERSADA, PT
Address of Employer / Recruitment Agency : KAWASAN INDUSTRI SEKUPANG KAVLING.13, BATAM

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LABORATORY REPORT

Test Name	Result Unit	Reference Range
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LIVER FUNCTION TEST

Total Bilirubin	: 0.7 mg/dl	0.3 - 1.1
Direct Bilirubin	: 0.4 mg/dl	0.1 - 0.4
Indirect Bilirubin	: 0.3 mg/dl	0.2 - 0.7
Alkaline Phosphatase	: 74 U/L	30 - 120
SGOT	: 35 U/L	M: <= 35 F: <= 31
SGPT	:* 48 U/L	M: <= 45 F: <= 34
Gamma GT	:* 60 U/L	M: <= 49 F: <= 32

LIPID PROFILE TEST

Total Cholesterol	:* 250 mg/dl	<= 200
HDL - Cholesterol	: 54 mg/dl	M: > 35 F: > 45
LDL - Cholesterol	:* 173 mg/dl	50 - 140
Triglycerida	: 113 mg/dl	<= 204
Ratio Cholesterol (Total Chol : HDL)	:* 4.6	M: < 3.4 F: < 3.3

BLOOD SUGAR TEST

Nuchter	: 85 mg/dl	< 100
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RENAL FUNCTION TEST

Ureum	: 22 mg/dl	17 - 43
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SEROLOGI

TPHA	: Non Reactive	Non Reactive
HBsAg	: Negative	Negative
Anti HBs	: Negative	

URINE

Cannabinoid	: Negative	Negative
Methamphetamine	: Negative	Negative
Opiates	: Negative	Negative
Cocain	: Negative	Negative
Amphetamine	: Negative	Negative
Benzodiazepine	: Negative	Negative

OTHERS

BUN	: 10.3 mg/dl	8 - 22
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Date of Exam : 5 March 2021



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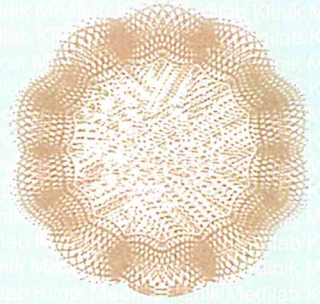
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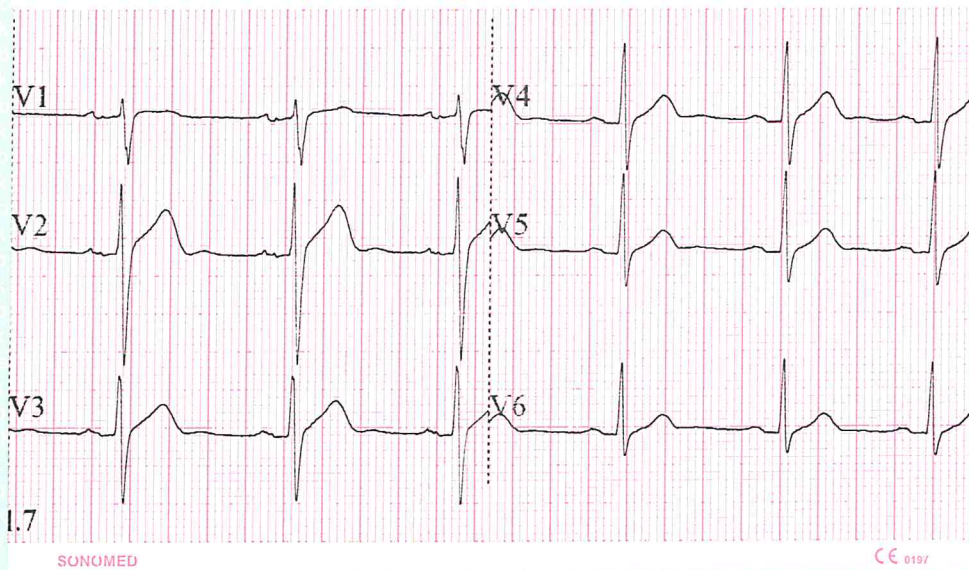
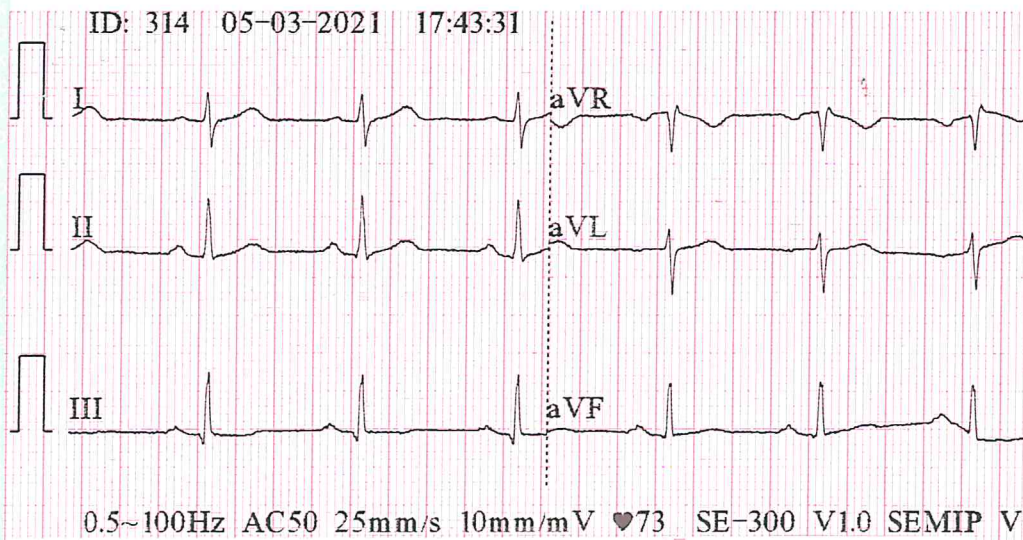
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E-mail: customercare@medilab-clinic.com, Website: www.medilab-clinic.com



ELECTROCARDIOGRAM INTERPRETATION (RESTING)

Name : MUHAMMAD FHADLY
Age : 26 Years
Gender : Male
Place/Date : BATAM/05 March 21
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



CONCLUSION : Normal Resting ECG

ADVICE

EXAMINER



dr. Rindi Nursaadah Sagala
002.1001-356/SIP/TM/DPMP/TSP-BTM/VIII/2020