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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

83

**CONFIDENTIAL**

No. Medical Record :   
00009/001/V/ISP/19

**PERSONAL DATA**

Name : AHMAD ROISUS SYIFA  
Birthday/Gender/Emp. ID : 10 August 1993 / Male / C 0320500  
Father's Name : MUSTOFA  
Address : RUSUN OTORITA BP SEKUPANG, BATAM  
Occupation : RSO  
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**

Weight : 69 Kg	Height : 161 Cm	3. Cardiovascular System	Yes/Abnormal	No/Normal
BMI : 26.61		a. Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>
		Systolic / Diastolic : 104 / 71 mm Hg		
		Pulse : 83 / min		
1. Vision	Yes/Abnormal	No/Normal		
a. Distant Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. Heart Disease	<input type="checkbox"/>
( Should be at least 6/12 in both eyes with or without glasses )			c. Varicose Veins	<input type="checkbox"/>
b. Near Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	4. Respiratory System	<input type="checkbox"/>
( Should be at least J2 in both eyes with or without glasses )			5. Skin-Chronic Disease	<input type="checkbox"/>
c. Colour Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	6. Abdomen	<input type="checkbox"/>
d. Any Organic Eye Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	7. Locomotor/Neurological	<input type="checkbox"/>
2. Hearing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8. Endocrine disorders	<input type="checkbox"/>
( Unable to hear ordinary conversation at 2 m )			9. Mental State	<input type="checkbox"/>

**LABORATORY TEST**

( Report Enclosed )

	Yes/Abnormal	No/Normal
1. Blood Count	<input checked="" type="checkbox"/>	<input 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 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, Myopia H52.1 R:6/7.5, L:6/6 MIM, Waist Circumference: 82 cm, Lab: HDL E78.4 46 mg/dl BHR, Triglyceride E78.1 209 mg/dl HR, Cholesterol Ratio E78 4 AR, Blood Count: Monocytosis D72.821 10.3%

**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, Low Fat Diet

Authentic Signature



Date of Exam : 4 May 2019



**DR. EBIET YUDI SANTOKO**

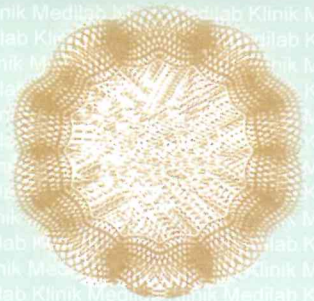




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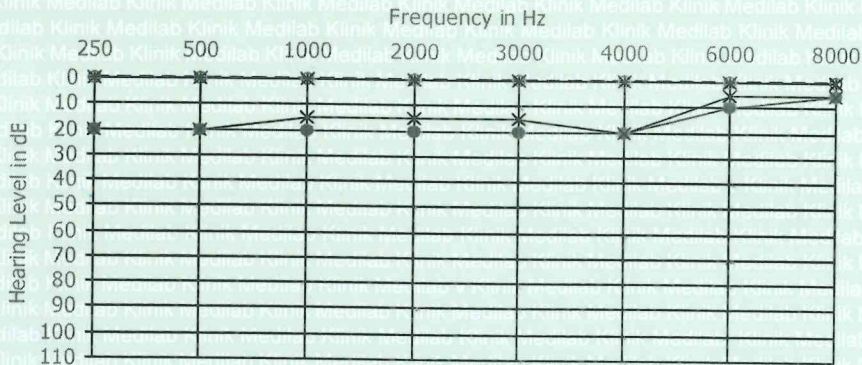
### AUDIOMETRY REPORT

#### Occupational History

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>
- Noisy Working Environment	
<input checked="" type="checkbox"/>	<input type="checkbox"/>
- Present/use of Hearing Protector	
<input type="checkbox"/>	<input type="checkbox"/>
- Period of Working	6.0 years

#### Medical History/Examination

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



#### Conclusion :

- Audiogram : Normal
- Hearing Impairment : Monaural : R : -7.50 %  
L : -11.25 %  
Hearing Handicap : -10.625 %
- Not a Noise Induced Hearing Loss

Date of Exam : 4 May 2019



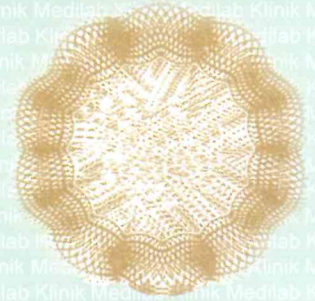
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AHMAD ROISUS

### LABORATORY REPORT

#### BLOOD COUNT

Test Name	Result	Unit	Reference Range
HGB	13.8	gr/dl	M: 13.2 - 17.3 F: 11.7 - 15.5
WBC	6.5	10 <sup>3</sup> /mm <sup>3</sup>	M: 3.8 - 10.6 F: 3.6 - 11.0
RBC	5.42	10 <sup>6</sup> /mm <sup>3</sup>	M: 4.4 - 5.9 F: 3.8 - 5.2
ESR	2	mm/hr	M: 0 - 10 F: 0 - 20
HCT	42.2	%	M: 40 - 52 F: 35 - 47
PLT	414	10 <sup>3</sup> /mm <sup>3</sup>	150 - 440
Differential Count			
- LYM	35.7	%	25 - 40
- MON	*	10.3	% 2 - 8
- GRA	54.0	%	43 - 76

#### URINE FEME

Macroscopy	Result	Microscopy	Result
- pH	6	- WBC/HPF	Occ/HPF
- Specific Gravity	1.010	- RBC/HPF	Nil/HPF
- Glucossa	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 Abnormalities.

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.

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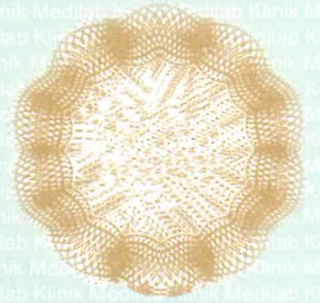


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**PULMONARY FUNCTION TEST**

**Occupation History**

	Yes	No
- Dusty Working Environment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
- Present/use of Protective Equipment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
- Period of Working	0.0 years	

**Medical History**

	Yes	No	If Yes, when
- Lung Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
- Breathlessness/Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
- Coughed Up Blood	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

	BEST VALUES		
	Pred.	MEASURED	%Pred
FVC	4.28	3.66	86
FEV1	3.71	3.21	87
FEV1/FVC	82.7	87.7	106
PEF	8.96	8.65	97
FEF2575	4.75	3.96	83

PARAMETER		Pred.	PRE#1	%Pred	PRE#2	PRE#3
FVC	L	4.28	3.66	86	3.57	3.59
FEV1	L	3.71	3.18	86	3.21	3.17
FEV1/FVC	%	82.7	86.9	105	89.9	88.3

FVC Normal Value : 3.577  
 FEV1 Normal Value : 3.109  
 FEV1/FVC % Normal Value : 88 %  
 FVC % Predicted Value : 102 %  
 FEV1 % Predicted Value : 103 %  
 FEV1/FVC % Predicted Value : 100 %

**Interpretation : Normal Spirometri**

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Predicted Value based on Indonesian Pneumobile Project, Reference spirometric values of healthy Indonesian schoolchildren and working adults using equipment and methods that meet American thoracic Society (ATS) 1987 recommendations, 1993



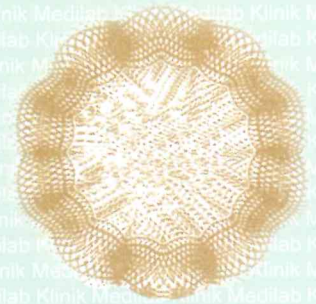


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**LABORATORY REPORT**

Test Name	Result Unit	Reference Range
<b>LIVER FUNCTION TEST</b>		
Total Bilirubin	0.4 mg/dl	0.3 - 1.1
Direct Bilirubin	0.1 mg/dl	0.1 - 0.4
Indirect Bilirubin	0.3 mg/dl	0.2 - 0.7
Alkaline Phosphatase	55 U/L	30 - 120
SGOT	20 U/L	M: <= 35 F: <= 31
SGPT	34 U/L	M: <= 45 F: <= 34
Gamma GT	28 U/L	M: <= 49 F: <= 32
<b>LIPID PROFILE TEST</b>		
Total Cholesterol	185 mg/dl	<= 200
HDL - Cholesterol	46 mg/dl	M: > 35 F: > 45
LDL - Cholesterol	97 mg/dl	50 - 140
Triglycerida	* 209 mg/dl	<= 204
Ratio Cholesterol ( Total Chol : HDL )	* 4	M: < 3.4 F: < 3.3
<b>BLOOD SUGAR TEST</b>		
Nuchter	57 mg/dl	< 100
<b>RENAL FUNCTION TEST</b>		
Ureum	26 mg/dl	17 - 43
<b>SEROLOGI</b>		
TPHA	Non Reactive	Non Reactive
HBsAg	Negative	Negative
Anti HBs	Negative	
<b>URINE</b>		
Cannabinoid	Negative	Negative
Methamphetamine	Negative	Negative
Opiates	Negative	Negative
Cocain	Negative	Negative
Amphetamine	Negative	Negative
Benzodiazepine	Negative	Negative
<b>OTHERS</b>		
BUN	12.1 mg/dl	8 - 20
Breath Alcohol Test	0.000 %BAC	< 0.02 %BAC is negative

Date of Exam : 4 May 2019



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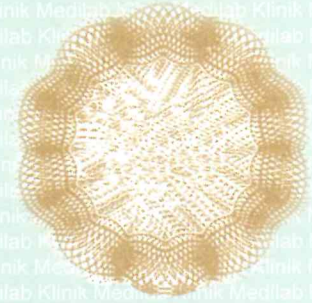


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AHMAD ROISUS

**LABORATORY REPORT**

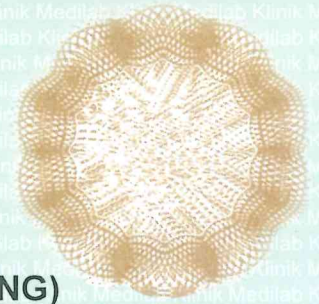
Test Name	Result Unit	Reference Range
		>= 0.02-0.039 %BAC: cannot perform safety sensitive function
		>= 0.04 %BAC is a violation of rule

Date of Exam : 4 May 2019



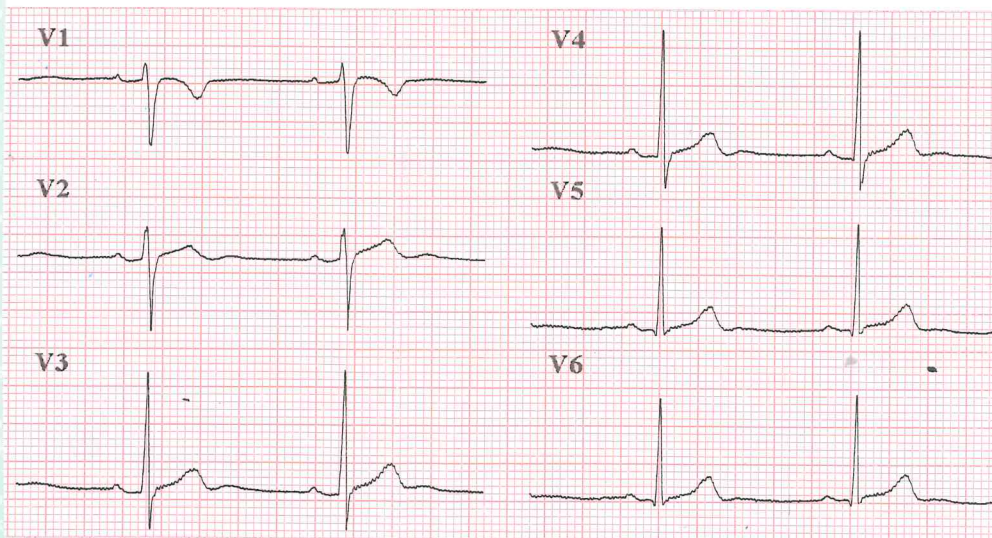
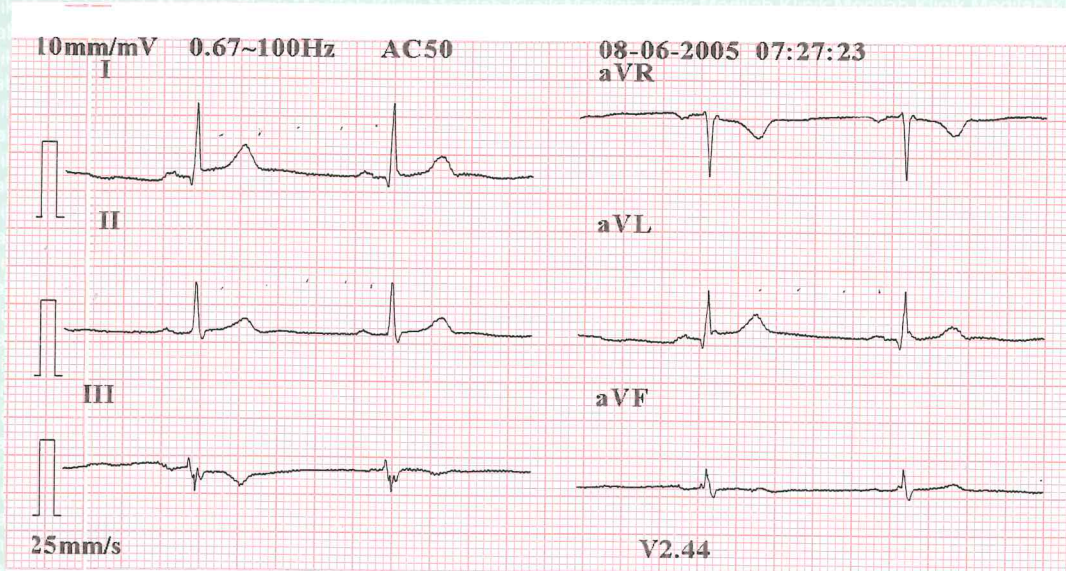
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**ELECTROCARDIOGRAM INTERPRETATION (RESTING)**

Name : Ahmad Roisus Syifa  
Age : 25 years  
Sex : Male  
Place/Date : Batam, May 04<sup>th</sup> 2019  
Company's name : INSPEKTINDO SINERGI PERSADA, PT



**CONCLUSION : Normal Resting ECG**  
**EXAMINER :**



**dr. REZGA AGNELA VALBETRI**  
Examining Physician



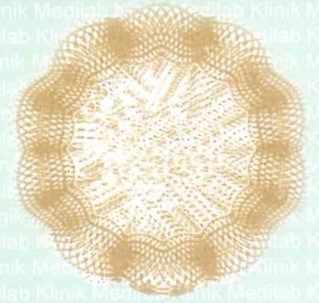


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**EYE EXAMINATION REPORT**

**Identification of Applicant**

**Applicant's Name** : Ahmad Roisus Syifa  
**Sex/Age** : Male/ 25 Years  
**Address** : Rusun Otorita BP Sekupang  
**Company's Name** : INSPEKTINDO SINERGI PERSADA, PT



AHMAD ROISUS

<b>Distant vision acuity ( Snellen Chart )</b>		<b>Near vision acuity ( Jaeger Test )</b>	
<b>Right Eye</b> : 6/7.5 Without Glasses	<b>Left Eye</b> : 6/6 Without Glasses	<b>Both Eyes</b> : J1 Without Glasses	
<b>Colour Vision ( Ishihara Test )</b> : Normal			
<b>dr. Ebiet Yudi Santoko</b>			
<b>Examiner's Name</b>		<b>Examiner's Signature</b>	
<b>Batam, May 04<sup>th</sup>, 2019</b>			
<b>Place, Date of eye examination</b>		<b>Official Stamp of Medical Practitioner</b>	





MEDICAL FITNESS CERTIFICATE

Doc. n. FORM-COR-HR-HLT-040-E

Rev. 03

26/09/16

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Ref. doc. OPR-COR-HR-HLT-001-E

MEDICAL FITNESS CERTIFICATE

issued in accordance with Oil & Gas UK Guidelines, Saipem Corporate Standards OPR-COR-HR-HLT-001-E, STD-COR-HLTCLI-001-1, IMO and STCW Guidelines on medical examination

Full name (in block letters)	Date of Birth	Occupation
AAAMAD ROISUS SARA	10.08.1993	RADIASION SAFETY OFFICER

This Health Certificate is valid until: 3 - 5 - 2020

Fit  
 Fit with prescriptions and/or restrictions  
 Unfit

offshore  
 permanent

onshore  
 temporary for months .....  
 permanent  
 temporary for months .....

Specify prescriptions and/or restrictions .....

**FIT TO WORK**

*[Handwritten Signature]*  
 Applicant's signature in the Doctor's presence  
 Batam  
 Place

4 - 5 - 2019  
 Day, Month, Year

**KLINIK MEDILAB**  
 Komplek Taman Kiaga Suka Jadi Blok J No. 3A-6 Batam  
 Tel: 0778-7372022, 7372023 Fax: 0778-7372024  
*[Handwritten Signature]*  
 dr. Ebiet Yudi Santoko  
 Doctor's stamp and signature

Employer must provide the personal protective equipment specific to the activity





MEDICAL REPORT

Doc. n. FORM-COR-HR-HLT-039-E

Rev. 02 | 06/11/15 | Page 1 of 3

Ref. doc. OPR-COR-HR-HLT-001-E

1. PERSONAL ANAMNESIS

Name in full ARMAD ROISUS SYLPA Date of Birth 10/08/1953 Sex  M  F  
 Occupation RGO Badge No.  Blood Group  Rh

Please tick box <input type="checkbox"/>		Yes	No	Details if "yes" (including dates and duration and any other relevant information)
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 checked="" type="checkbox"/>	
b)	Smokers: How much do you smoke per day?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cigarettes <input type="checkbox"/> Cigares <input type="checkbox"/> Pipes <input type="checkbox"/> Number smoked <input type="checkbox"/>
c)	What is the average daily consumption of alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father	53	HEALTHY		
Mother	53	HEALTHY		
Brother / Sister	12	HEALTHY		
Brother / Sister	6	HEALTHY		
Brother / Sister				

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 4-5-2019





**MEDICAL REPORT**

Doc. n. FORM-COR-HR-HLT-039-E

Rev. 03      07/12/2016      Page 2 of 3

Ref. doc. OPR-COR-HR-HLT-001-E

**3. SUMMARY OF MEDICAL HISTORY MR. /MRS. AHMAD ROISUS SYIFA**

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
1. Ear infection / Sinusitis / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8. Endocrine disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Nose, mouth or throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9. Hernia / Hydrocele / Piles / Fissures	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Color blindness / Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	10. Fistula / Appendicitis / Varicocele	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Frequent headaches / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	11. Malaria / Tropical Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Epilepsy / Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	12. Skin disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	13. Cancer or tumor	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	14. Allergy to foods / drugs	<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"
<b>8. Measurement &amp; Physical Description</b>			
a) Measurements (to be taken in indoor clothing)			Height: 161 cm      Weight: 69 Kg BMI: 26.61 Kg/m <sup>2</sup> Waist Circumference: 82 cm
b) Please describe general appearance and build:			
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"/>	
<b>9. Cardio-vascular System &amp; Blood pressure</b>			
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)	➔		Systolic / Diastolic: 104 / 71 mmHg      Pulse Rate: 83x/mnt
<b>10. Respiratory System</b>			
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"/>	
<b>11. Genito / Urinary &amp; Digestive System</b>			
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"/>	
<b>12. Nervous System</b>			
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"/>	
<b>13. Sense Organs</b>			
a) Is there any affection of the eyes, ears, nose or tongue	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>Vision</b>	<b>Far Vision</b>	<b>Near Vision</b>	<b>Color Vision</b>
Uncorrected	OD <u>6/7.5</u> OS <u>6/6</u>	OD <u>J1</u> OS <u>J1</u>	Adequate <input checked="" type="checkbox"/>
Corrected	OD <u>-</u> OS <u>-</u>	OD <u>-</u> OS <u>-</u>	Defective

Remarks:





MEDICAL REPORT

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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	Normal Lung Function
5. Blood Examination Report (Please, attach the results of the following examinations or indicate here below the results):	
1) Hemoglobin 13.8 gr/dl	10) MCV (*) 46 mg/dl
2) RBC 5.42 x 10 <sup>6</sup> /mm <sup>3</sup>	11) MCM (*) 97 mg/dl
3) ESR 2 mm/hr	12) MCHC (*) 209 mg/dl
4) WBC 6.5 x 10 <sup>3</sup> /mm <sup>3</sup>	13) Platelet 414 x 10 <sup>3</sup> /mm <sup>3</sup>
5) Neutrophils	14) Reticulocyte (*) 0.4 mg/dl
6) Lymphocytes 35.7 %	15) Hematocrit 42.2 %
7) Monocytes 10.3 %	16) Glycemia 57 mg/dl
8) Eosinophils	17) Blood Urea 26 mg/dl
9) Basophils	18) Total Cholesterol 185 mg/dl
	19) HDL Cholesterol 46 mg/dl
	20) LDL Cholesterol 97 mg/dl
	21) Triglycerides 209 mg/dl
	22) Total Bilirubine 0.4 mg/dl
	23) Direct Bilirubin 0.1 mg/dl
	24) Alkaline Phosphatase 55 u/L
	25) AST (SGOT) 20 u/L
	26) ALT (SGPT) 34 u/L
	27) Gamma GT 28 u/L

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: 6, SG: 1.010, 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 0.000%BAC
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: 5/3/2020

I have examined Mr./Mrs. AHMAD ROISUS SYIFA and found him/her (tick the box)

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

SAIPEM  
 Komplek Taman Ningsu Suka Jadi Blok J No. 3A-6 Batam  
 Tel : 0778 - 7372022, 7372023 Fax : 0778 - 7372024

Dr. Ebiot Yudi Satrio  
 Examining Doctor's Signature  
 (Stamp, Signature, Name and address of the Physician)

Date: 5/4/2019