

1. PERSONAL ANAMNESIS

| | | |
|--|---|--|
| Name in full <input style="width: 80%;" type="text" value="DAPINEVRIA"/> | Date of Birth <input style="width: 80%;" type="text" value="08-12-1983"/> | Sex <input checked="" type="radio"/> M <input type="radio"/> F |
| Occupation <input style="width: 80%;" type="text"/> | Badge No. <input style="width: 80%;" type="text"/> | Blood Group <input type="radio"/> Rh <input type="radio"/> |

| 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 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? | → | | Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes <input type="checkbox"/> Number smoked <input 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 | 70 | FT | | |
| Mother | 68 | FT | | |
| Brother / Sister | 40 | FT | | |
| Brother / Sister | 35 | FT | | |
| 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 19/13/2021

3. SUMMARY OF MEDICAL HISTORY MR. /MRS. DARMENDRA

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" |
|--|-------------------------------------|-------------------------------------|---|
| 8. Measurement & Physical Description | | | |
| a) Measurements (to be taken in indoor clothing) | | | Height: 169 cm Weight: 76 Kg |
| b) Please describe general appearance and build: | | | BMI: 26.60 Kg/m ² Waist Circumference: 96 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) | → | | Systolic / Diastolic: 135 / 86 Pulse Rate: 72x/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 checked="" type="checkbox"/> | <input type="checkbox"/> | Dental Caries K02 1 |
| 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 type="checkbox"/> | <input checked="" type="checkbox"/> | |
| Vision | Far Vision | Near Vision | Color Vision |
| Uncorrected | OD <u>6/6</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:

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 | 15.3 gr/dl | 10) MCV (*) | 19) HDL Cholesterol | 46 mg/dl | |
| 2) RBC | 5.09 x 10 ⁶ /mm ³ | 11) MCM (*) | 20) LDL Cholesterol | 168 mg/dl | |
| 3) ESR | 12 mm/hr | 12) MCHC (*) | 21) Triglycerides | 211 mg/dl | |
| 4) WBC | 9.1 x 10 ³ /mm ³ | 13) Platelet | 308 x 10 ³ /mm ³ | 22) Total Bilirubin | 0.5 mg/dl |
| 5) Neutrophils | | 14) Reticulocyte (*) | | 23) Direct Bilirubin | 0.2 mg/dl |
| 6) Lymphocytes | 33.2 % | 15) Hematocrit | 46.4 % | 24) AlkalinePhosphatase | 73 u/L |
| 7) Monocytes | 9.8 % | 16) Glycemia | 98 mg/dl | 25) AST (SGOT) | 27 u/L |
| 8) Eosinophils | | 17) Blood Urea | - | 26) ALT (SGPT) | 38 u/L |
| 9) Basophils | | 18) Total Cholesterol | 256 mg/dl | 27) Gamma GT | 38 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: 5, SG: 1.015, Glucosaa: (-), 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:18-Mar-2022

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

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

DR. REZGA AGNELA
 Examining Doctor's Signature
 (Stamp, Signature, Name and address of the Physician)

Date: 19-Mar-2021

dr. Rezga Agnela
Examining Physician

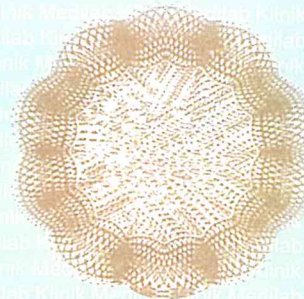


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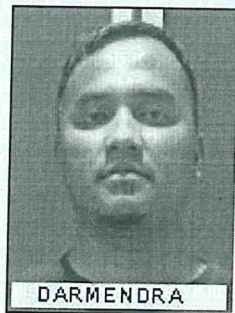
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E-mail: customercare@medilab-clinic.com, Website: www.medilab-clinic.com



EYE EXAMINATION REPORT

IDENTIFICATION OF APPLICANT

Applicant's Name : DARMENDRA
DOB/Gender/Emp. ID: 8 December 1983 / Male / 13041
Address : PERUM GARDAN RAYA BLOK CA6 NO 7 BATAM CENTER, BATAM
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



DARMENDRA

Distant Vision Acuity (Snellen Chart)
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 (Ishihara's Test) Normal

Visual Field Test (Confrontation Test) -

Grey Test -

Depth Test -

DR. REZGA AGNELA VALBETRI

Examiner's Name

Examiner's Signature

BATAM, 19 March 21



Place, Date of eye examination

Official Stamp of Medical Practitioner



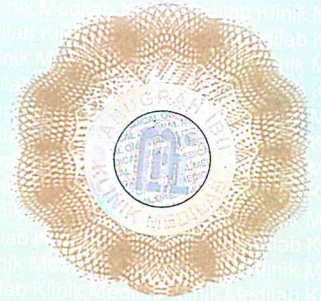
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HEALTH SCREENING REPORT

Preemployment Physical Examination

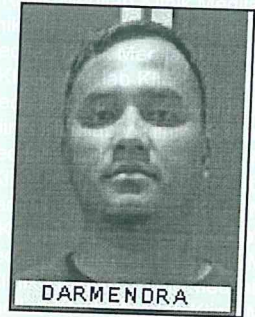
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CONFIDENTIAL

No. Medical Record : 
00030/005/III/ISP/21

PERSONAL DATA

Name : DARMENDRA
 Birthday/Gender/Emp. ID : 8 December 1983 / Male / 13041
 Father's Name : DARMAINI
 Address : PERUM GARDAN RAYA BLOK CA6 NO 7 BATAM CENTER, BATAM
 Occupation : ASSISTANT 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

| | | | | |
|--|--------------------------|---------------------------------------|---------------------------|-------------------------------------|
| Weight : 76 Kg | Height : 169 Cm | 3. Cardiovascular System | Yes/Abnormal | No/Normal |
| BMI : 26.60 | | a. Blood Pressure | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | | Systolic / Diastolic : 135 / 86 mm Hg | | |
| | | Pulse : 72 / 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 checked="" type="checkbox"/> |
| b. Near Vision | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 4. Respiratory System | <input checked="" type="checkbox"/> |
| (Should be at least J2 in both eyes with or without glasses) | | | 5. Skin-Chronic Disease | <input checked="" 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 checked="" type="checkbox"/> |
| (Unable to hear ordinary conversation at 2 m) | | | 9. Mental State | <input checked="" 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, Dental Caries K02 1, Waist Circumference: 96 cm, Lab: Total Cholesterol E78.0 256 mg/dl VHR, HDL E78.4 46 mg/dl BHR, LDL E78.4 168 mg/dl HR, Triglyceride E78.1 211 mg/dl HR, Cholesterol Ratio E78 5.6 AR, Blood Count: ESR R70.0 12 mm/hr MIE, Monocytosis D72.821 9.8%

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, Teeth Hygiene, Low Fat Diet

Authentic Signature



DR. REZGA AGNELA VALBETRI

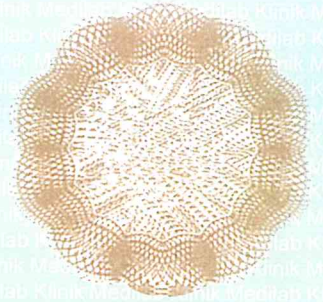
Date of Exam : 19 March 2021





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HEALTH SCREENING REPORT

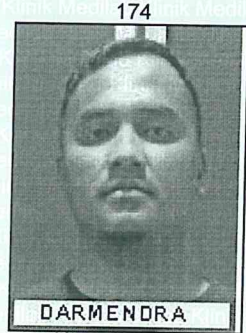
Preemployment Physical Examination

CONFIDENTIAL

No. Medical Record : 
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LABORATORY REPORT

BLOOD COUNT

| Test Name | Result | Unit | Reference Range | | |
|------------------------------------|--------|----------------------------------|-----------------|-------------------|----------------|
| HGB | 15.3 | gr/dl | M: 13.2 - 17.3 | F: 11.7 - 15.5 | |
| WBC | 9.1 | 10 ³ /mm ³ | M: 3.8 - 10.6 | F: 3.6 - 11.0 | |
| RBC | 5.09 | 10 ⁶ /mm ³ | M: 4.4 - 5.9 | F: 3.8 - 5.2 | |
| ESR | * | 12 mm/hr | M: 0 - 10 | F: 0 - 20 | |
| HCT | 46.4 | % | M: 40 - 52 | F: 35 - 47 | |
| PLT | 308 | 10 ³ /mm ³ | 150 - 440 | | |
| Differential Count | | | | | |
| - LYM | 33.2 | % | 25 - 40 | | |
| - MON | * | 9.8 | 2 - 8 | | |
| - GRA | 57.0 | % | 43 - 76 | | |
| Indicator of Infection | | | | | |
| - Neutrofil Lymphocyte Ratio (NLR) | 1.71 | % | > 3.13 Cautious | 6 - 9 Suspicious | > 9 Perilous |
| - Absolute Lymphocyte Count (ALC) | 3021 | % | < 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 |
| - 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 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 : 19 March 2021

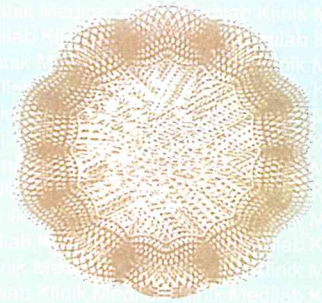


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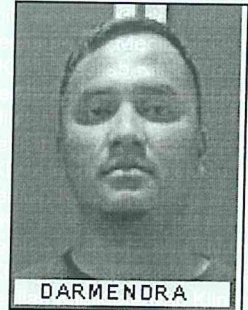
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HEALTH SCREENING REPORT


Preemployment Physical Examination

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DARMENDRA

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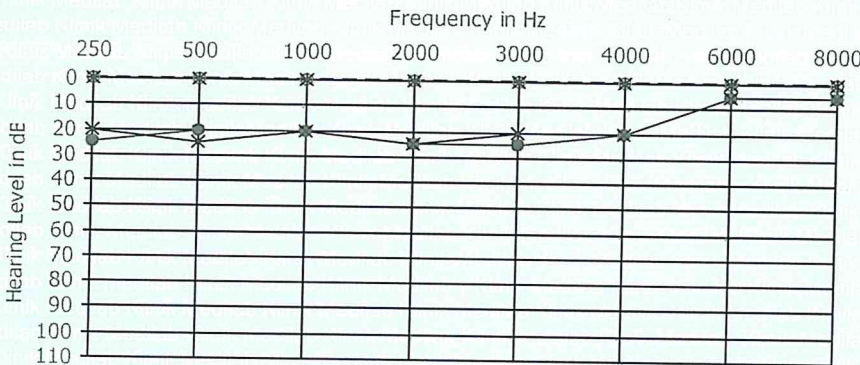
AUDIOMETRY REPORT

Occupational History

| | |
|------------------------------------|-------------------------------------|
| Yes | No |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| - Noisy Working Environment | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| - Present/use of Hearing Protector | |
| <input type="checkbox"/> | |
| - Period of Working | 0.0 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"/> |



● REAC
 × LEAC
 ○ REBC
 × LEBC

Conclusion :

- Audiogram : Normal
- Hearing Impairment : Monaural : R : -3.75 %
L : -3.75 %
Hearing Handicap : -3.750 %
- Not a Noise Induced Hearing Loss

Date of Exam : 19 March 2021



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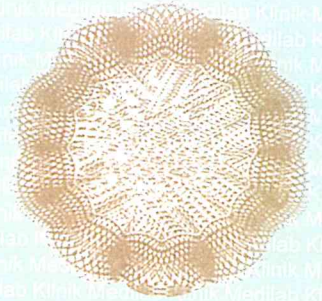


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Telp: (0778) 7372022, 7372023, 0811 770 1188, 0811 770 1199. Fax: (0778) 7372024
E-mail: customercare@medilab-clinic.com, Website: www.medilab-clinic.com



HEALTH SCREENING REPORT

Preemployment Physical Examination

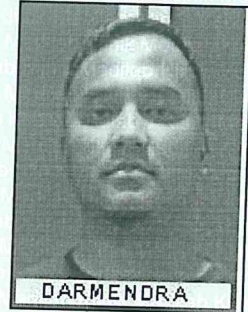
CONFIDENTIAL

No. Medical Record : 
00030/005/III/ISP/21

174

PERSONAL DATA

Name : DARMENDRA
 Birthday/Gender/Emp. ID : 8 December 1983 / Male / 13041
 Father's Name : DARMAINI
 Address : PERUM GARDAN RAYA BLOK CA6 NO 7 BATAM CENTER, BATAM
 Occupation : ASSISTANT INSPECTOR
 Name of Employer / Recruitment Agency : INSPEKTINDO SINERGI PERSADA, PT
 Address of Employer / Recruitment Agency : KAWASAN INDUSTRI SEKUPANG KAVLING.13, BATAM



LABORATORY REPORT

| Test Name | Result Unit | Reference Range |
|--|--------------|-------------------|
| LIVER FUNCTION TEST | | |
| Total Bilirubin | 0.5 mg/dl | 0.3 - 1.1 |
| Direct Bilirubin | 0.2 mg/dl | 0.1 - 0.4 |
| Indirect Bilirubin | 0.3 mg/dl | 0.2 - 0.7 |
| Alkaline Phosphatase | 73 U/L | 30 - 120 |
| SGOT | 27 U/L | M: <= 35 F: <= 31 |
| SGPT | 38 U/L | M: <= 45 F: <= 34 |
| Gamma GT | 38 U/L | M: <= 49 F: <= 32 |
| LIPID PROFILE TEST | | |
| Total Cholesterol | 256 mg/dl | <= 200 |
| HDL - Cholesterol | 46 mg/dl | M: > 35 F: > 45 |
| LDL - Cholesterol | 168 mg/dl | 50 - 140 |
| Triglycerida | 211 mg/dl | <= 204 |
| Ratio Cholesterol (Total Chol : HDL) | 5.6 | M: < 3.4 F: < 3.3 |
| BLOOD SUGAR TEST | | |
| Nuchter | 98 mg/dl | < 100 |
| RENAL FUNCTION TEST | | |
| Ureum | 20 mg/dl | 17 - 43 |
| SEROLOGI | | |
| TPHA | Non Reactive | Non Reactive |
| HBsAg | Negative | Negative |
| Anti HBs | Negative | Negative |
| URINE | | |
| Cannabinoid | Negative | Negative |
| Methamphetamine | Negative | Negative |
| Opiates | Negative | Negative |
| Cocain | Negative | Negative |
| Amphetamine | Negative | Negative |
| Benzodiazepine | Negative | Negative |
| OTHERS | | |
| BUN | 9.3 mg/dl | 8 - 22 |

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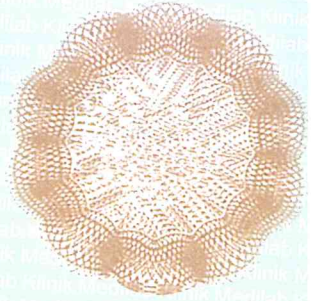


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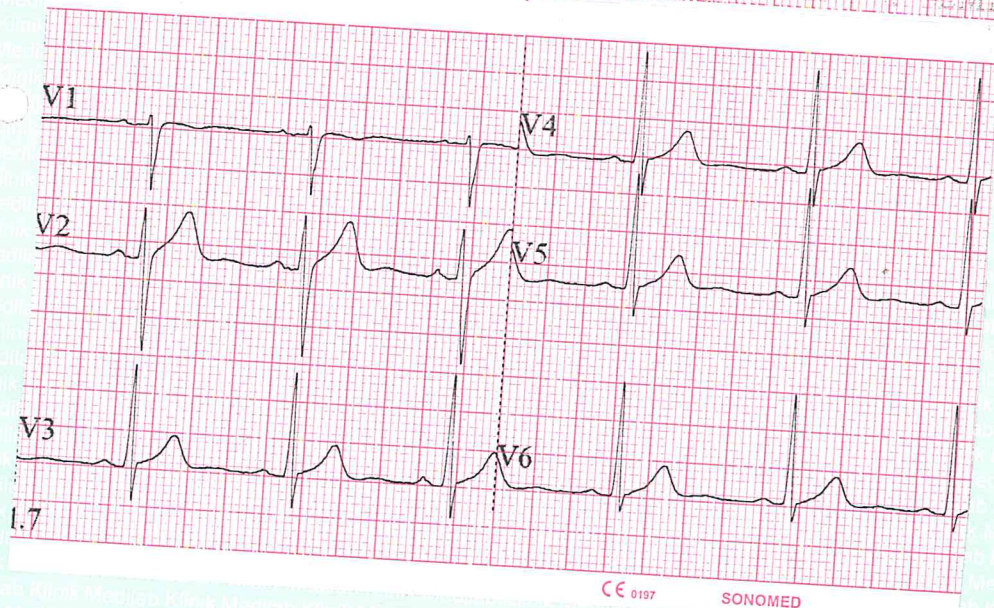
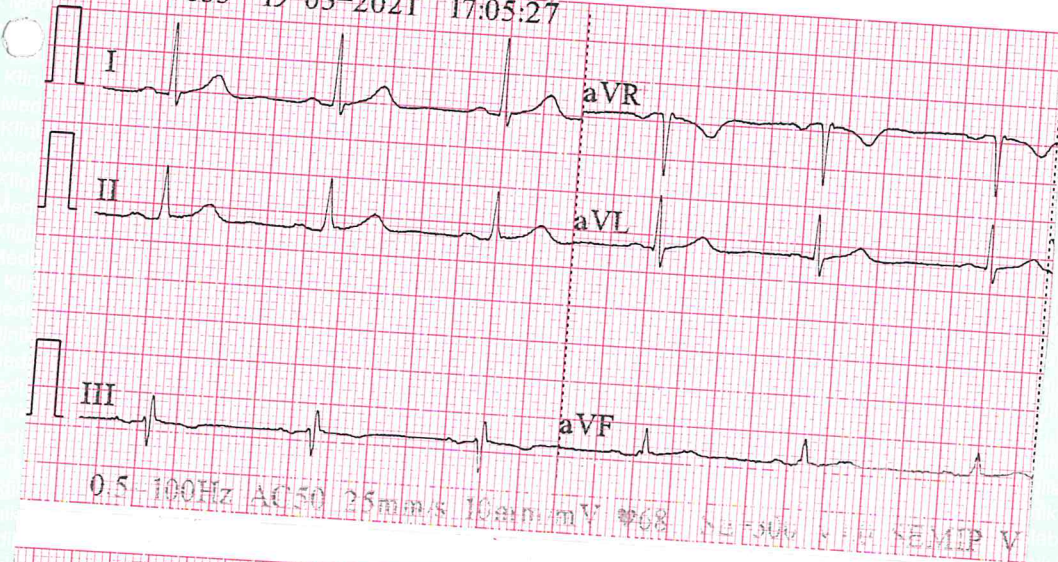
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ELECTROCARDIOGRAM INTERPRETATION (RESTING)

Name : DARMENDRA
Age : 37 Years
Gender : Male
Place/Date : BATAM/19 March 21
Company's Name : INSPEKTINDO SINERGI PERSADA, PT

ID: 633 19-03-2021 17:05:27



CE 0197 SONOMED

CONCLUSION : Normal Resting ECG
ADVICE
EXAMINER



dr. Rinda Nursaadah Sagala
002.1/001-356/SIP.TM/DPNPTSP-BTM/VIII/2020