



### MEDICAL FITNESS CERTIFICATE MEDICAL REPORT

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

## MEDICAL FITNESS CERTIFICATE

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

Full name (in block letters)	Date of Birth	Occupation
DARMENDRA	8 / 12 / 1983	ASST INSPECTOR

This Health Certificate is valid until: 4 / 6 / 2021

- |   |                                    |   |
|---|------------------------------------|---|
| <input checked="" type="checkbox"/> Fit                             | <input type="checkbox"/> offshore  | <input checked="" type="checkbox"/> onshore         |
| <input type="checkbox"/> Fit with prescriptions and/or restrictions | <input type="checkbox"/> permanent | <input type="checkbox"/> temporary for months ..... |
| <input type="checkbox"/> Unfit                                      | <input type="checkbox"/> permanent | <input type="checkbox"/> temporary for months ..... |

Specify prescriptions and/or restrictions .....

**FIT TO WORK**

Applicant's signature in the Doctor's presence

Baram

5 / 6 / 2020

Place

Day, Month, Year

KLINIK  
MEDILAB  
Tel: 0778 - 7372022, 7372023 Fax: 0778 - 7372024  
dr. Ebiel Yudi Santia  
Examination Center

Doctor's stamp and signature

*Employer must provide the personal protective equipment specific to the activity*



## MEDICAL FITNESS CERTIFICATE MEDICAL REPORT

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### 1. PERSONAL ANAMNESIS

Name in full	<u>DARMENDRA</u>	Date of Birth	<u>8/12/1983</u>	<input checked="" type="radio"/> M <input type="radio"/> F
Occupation	<u>ASST INSPECTOR</u>	Badge No.	<input type="text"/>	Blood Group <input type="text"/> Rh <input type="text"/>

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 checked="" type="checkbox"/>	<input 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="text"/>	<input type="text"/>	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?	<input type="text"/>	<input type="text"/>	

### 2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father	<u>55</u>			
Mother	<u>55</u>			
Brother / Sister	<u>40</u>			
Brother / Sister	<u>38</u>			
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 5/6/2020



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**3. SUMMARY OF MEDICAL HISTORY OF MR. /MRS. DARMENORA**

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	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
1. Ear infection / Sinusitis / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8. Endocrine disorder	<input type="checkbox"/>	<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 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 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 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 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 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 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)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Height: <u>168</u> cm	Weight: <u>74</u> Kg
b) Please describe general appearance and build:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	BMI: <u>26.21</u> Kg/m <sup>2</sup>	W aist Circumference: <u>82</u> 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"/>	<input checked="" type="checkbox"/>		
d) Is there any enlargement of lymph nodes or thyroid gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Are there any scars of material significance?	<input type="checkbox"/>	<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 type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there any irregularity of rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is there any abnormality in the arterial pulse?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Are there any varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Blood Pressure: (please record opposite)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Systolic / Diastolic: <u>131 / 83</u> mmHg	Pulse Rate: <u>82</u> %
<b>10. Respiratory System</b>					
a) Is there any abnormality in the shape and development of the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Are there any abnormal physical signs in the lungs?	<input type="checkbox"/>	<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 type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there any abnormal tenderness, enlargement or other palpable abnormality in abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is a hernia present	<input type="checkbox"/>	<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 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 type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there anything to suggest a tendency to psychiatric disorder?	<input type="checkbox"/>	<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 type="checkbox"/>	<input checked="" type="checkbox"/>		
Vision	Far Vision		Near Vision		Color Vision
Uncorrected	OD <u>6/c</u>	OS <u>6/c</u>	OD <u>J1</u>	OS <u>J1</u>	Adequate <input checked="" type="checkbox"/>
Corrected	OD _____	OS _____	OD _____	OS _____	Defective

Remarks:





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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

2. ECG Report NORMAL Resting ECG

3. Audiogram Report NORMAL

4. Spirometry Report NA

5. Blood Examination Report (Please, attach the results of the following examinations or indicate here below the results):
1) Hemoglobin 2) RBC 3) ESR 4) WBC 5) Neutrophils 6) Lymphocytes 7) Monocytes 8) Eosinophils 9) Basophils
10) MCV (\*) 11) MCM (\*) 12) MCHC (\*) 13) Platelet 14) Reticulocyte (\*) 15) Hematocrit 16) Glycemia 17) Blood Urea 18) Total Cholesterol
19) HDL Cholesterol 20) LDL Cholesterol 21) Triglycerides 22) Total Bilirubin 23) Direct Bilirubin 24) Alkaline Phosphatase 25) AST (SGOT) 26) ALT (SGPT) 27) Gamma GT
See attachment

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): See attachment

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

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

(\*)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: 4/6/2021

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

FIT for (offshore/onshore) duty [checked] UNFIT for duty [ ] Pending [ ]

Examining Doctor's Signature: dr. Ebiet Yudi... (Stamp, Signature, Name and address of the Physician)

Date: 5/6/2020



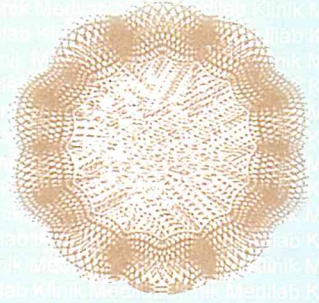


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# M•KLINIK MEDILAB

## 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



### EYE EXAMINATION REPORT

#### Identification of Applicant

Applicant's Name : Darmendra  
Sex/Age : Male/ 36 Years  
Address : Perum Garden Raya  
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



<b>Distant vision acuity ( Snellen Chart )</b>		<b>Near vision acuity ( Jaeger Test )</b>	
Right Eye	: 6/6 Without Glasses	Both Eyes	: J1 Without Glasses
Left Eye	: 6/6 Without Glasses		
<b>Colour Vision ( Ishihara Test )</b>		: Normal	

Dr. Ebiet Yudi Santoko  
Examiner's Name

Examiner's Signature

Batam, June 05<sup>th</sup>, 2020  
Place, Date of eye examination

Official Stamp of Medical Practitioner





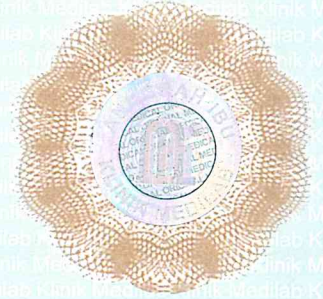
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### HEALTH SCREENING REPORT

Preemployment Physical Examination

121

#### CONFIDENTIAL

No. Medical Record :   
00007/002/VI/ISP/20

#### PERSONAL DATA

Name : DARMENDRA  
 Birthday/Gender/Emp. ID : 8 December 1983 / Male /  
 Father's Name : DARMAINI  
 Address : PERUM GARDEN RAYA, 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

Weight : 74 Kg	Height : 168 Cm	3. Cardiovascular System	Yes/Abnormal	No/Normal
BMI : 26.21		a. Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>
		Systolic / Diastolic : 131 / 83 mm Hg		
		Pulse : 82 / 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 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, Waist Circumference: 82 cm, Lab: Total Cholesterol E78.0 255 mg/dl VHR, HDL E78.4 59 mg/dl BHR, LDL E78.4 160 mg/dl HR, Cholesterol Ratio E78 4.3 AR, Nuchter: Pre-Diabetes R73.01 106 mg/dl, Blood Count: Monocytosis D72.821 9.9%

#### 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 & Sugar Diet

Authentic Signature

Date of Exam : 5 June 2020



DR. EBIET YUDI SANTOKO





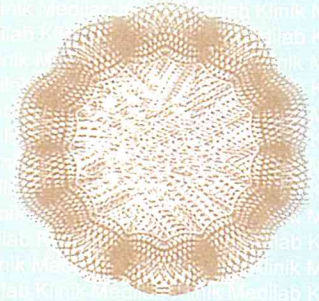
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### HEALTH SCREENING REPORT

Preemployment Physical Examination

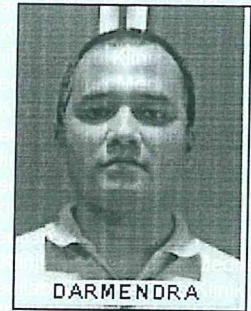
121

#### CONFIDENTIAL

No. Medical Record :   
00007/002/VI/ISP/20

#### PERSONAL DATA

Name : DARMENDRA  
 Birthday/Gender/Emp. ID : 8 December 1983 / Male /  
 Father's Name : DARMAINI  
 Address : PERUM GARDEN RAYA, BATAM  
 Occupation : ASST INSPECTOR  
 Name of Employer / Recruitment Agency : INSPEKTINDO SINERGI PERSADA, PT  
 Address of Employer / Recruitment Agency : KAWASAN INDUSTRI SEKUPANG KAVLING.13, BATAM



### LABORATORY REPORT

#### BLOOD COUNT

Test Name	Result Unit	Reference Range
HGB	16.0 gr/dl	M: 13.2 - 17.3 F: 11.7 - 15.5
WBC	7.5 10 <sup>3</sup> /mm <sup>3</sup>	M: 3.8 - 10.6 F: 3.6 - 11.0
RBC	4.88 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	44.7 %	M: 40 - 52 F: 35 - 47
PLT	313 10 <sup>3</sup> /mm <sup>3</sup>	150 - 440
Differential Count		
- LYM	34.2 %	25 - 40
- MON	* 9.9 %	2 - 8
- GRA	55.9 %	43 - 76

#### URINE FEME

Macroscopy	Result
- pH	6
- Specific Gravity	1.010
- Glucossa	Negative
- Protein	Negative
- Ketones	Negative
- 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.

Date of Exam : 5 June 2020



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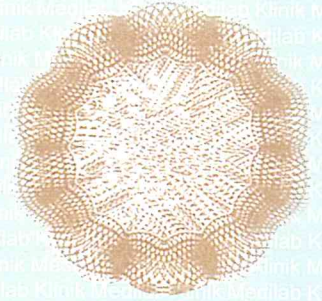


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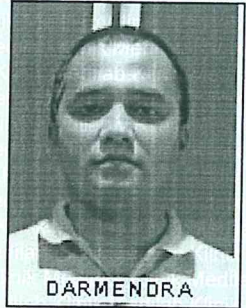
Preemployment Physical Examination

#### CONFIDENTIAL

No. Medical Record :   
00007/002/VI/ISP/20

121

#### PERSONAL DATA



DARMENDRA

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 Birthday/Gender/Emp. ID : 8 December 1983 / Male /  
 Father's Name : DARMAINI  
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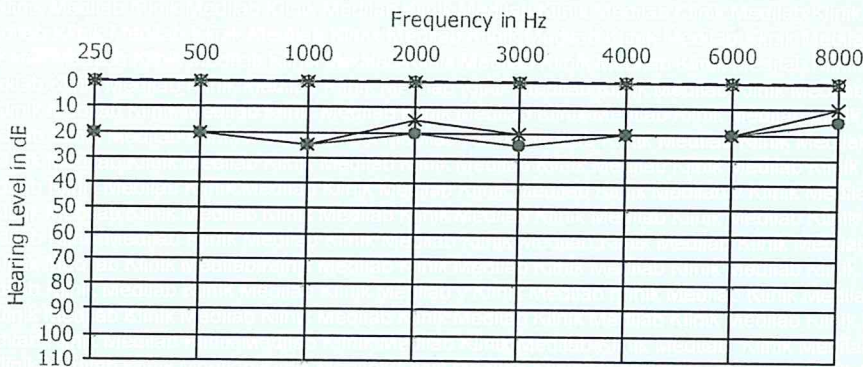
### AUDIOMETRY REPORT

#### Occupational History

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



#### Conclusion :

- Audiogram : Normal
- Hearing Impairment : Monaural : R : -3.75 %  
L : -7.50 %  
Hearing Handicap : -6.875 %
- Not a Noise Induced Hearing Loss

Date of Exam : 5 June 2020

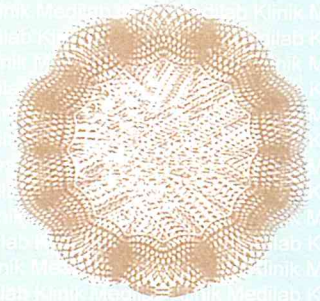


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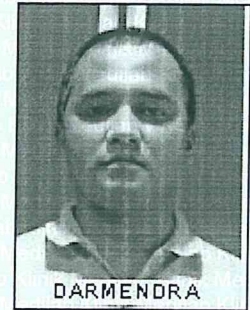
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Birthday/Gender/Emp. ID : 8 December 1983 / Male /  
Father's Name : DARMAINI  
Address : PERUM GARDEN RAYA, BATAM  
Occupation : ASST INSPECTOR  
Name of Employer / Recruitment Agency : INSPEKTINDO SINERGI PERSADA, PT  
Address of Employer / Recruitment Agency : KAWASAN INDUSTRI SEKUPANG KAVLING.13, BATAM



### LABORATORY REPORT

Test Name	Result Unit	Reference Range
<b>LIVER FUNCTION TEST</b>		
Total Bilirubin	: 0.8 mg/dl	0.3 - 1.1
Direct Bilirubin	: 0.3 mg/dl	0.1 - 0.4
Indirect Bilirubin	: 0.5 mg/dl	0.2 - 0.7
Alkaline Phosphatase	: 78 U/L	30 - 120
SGOT	: 27 U/L	M: <= 35 F: <= 31
SGPT	: 45 U/L	M: <= 45 F: <= 34
Gamma GT	: 34 U/L	M: <= 49 F: <= 32
<b>LIPID PROFILE TEST</b>		
Total Cholesterol	:* 255 mg/dl	<= 200
HDL - Cholesterol	: 59 mg/dl	M: > 35 F: > 45
LDL - Cholesterol	:* 160 mg/dl	50 - 140
Triglycerida	: 180 mg/dl	<= 204
Ratio Cholesterol ( Total Chol : HDL )	:* 4.3	M: < 3.4 F: < 3.3
<b>BLOOD SUGAR TEST</b>		
glicosa	:* 106 mg/dl	< 100
<b>RENAL FUNCTION TEST</b>		
Ureum	: 29 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	: 13.6 mg/dl	8.0 - 2.00

Date of Exam : 5 June 2020



>> Computer Generated Report, No Signature Required. <<





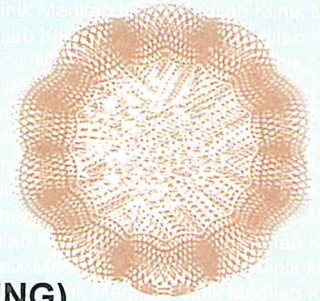
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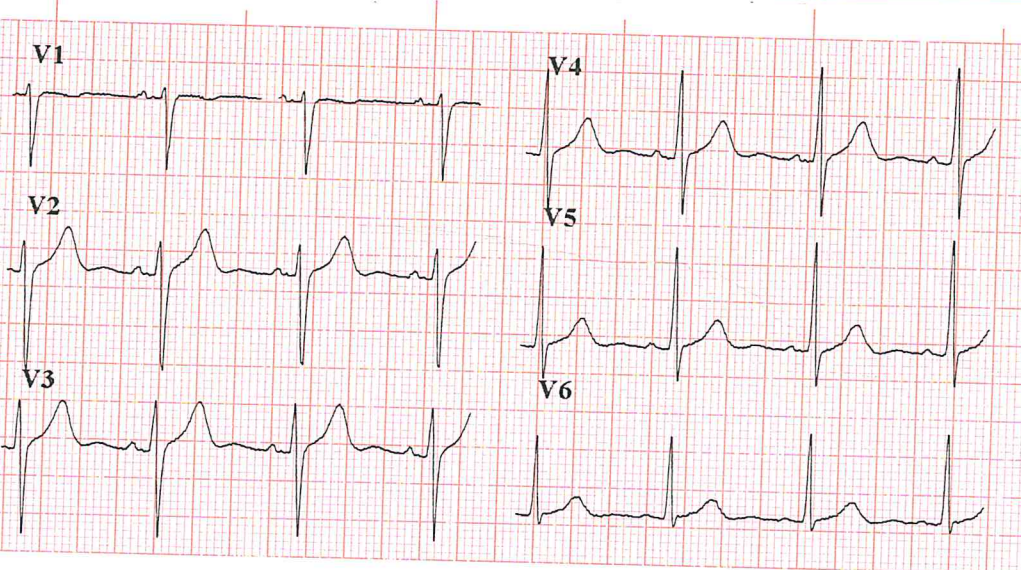
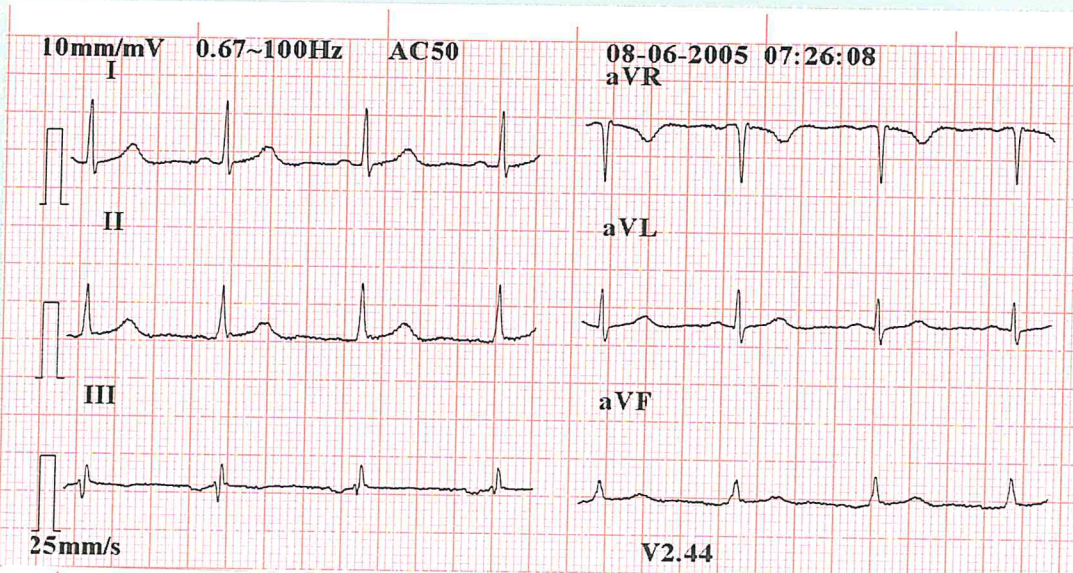
**PUSAT PEMERIKSAAN KESEHATAN TENAGA KERJA**

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



**ELECTROCARDIOGRAM INTERPRETATION (RESTING)**

Name : Darmendra  
Age : 36 Years  
Sex : Male  
Place/Date : Batam, June 05<sup>th</sup>, 2020  
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



CONCLUSION : **Normal Resting ECG**  
EXAMINER :

**dr. REZGA AGNELA VALBETRI**  
Examining Physician