



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
JOSUA SAMAT PARULIH S	03/07/1992	INSPECTOR

This Health Certificate is valid until: 07/10/2021

- | | | |
|---|------------------------------------|---|
| <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

BATAM
Place

09 / 10 / 2020
Day, Month, Year

KLINIK MEDILAB
Komplek Taman Niaga Suka Jati Blok J No. 3A-6 Batam
Tel : 0778 - 7372022 / 0778 - 7372023 Fax : 0778 - 7372024

Doctor's stamp and signature
dr. Rezga Agnela
Examining Physician

Employer must provide the personal protective equipment specific to the activity



MEDICAL FITNESS CERTIFICATE MEDICAL REPORT

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

1. PERSONAL ANAMNESIS

Name in full JOSUA SAKIAT PAPULAN (INAG) Date of Birth 03.07.92 Sex M F

Occupation 03.07. (1992) INSPEKTOR 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)
		<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 checked="" type="checkbox"/>	
b)	Smokers: How much do you smoke per day?	<input type="text"/>	<input type="text"/>	
c)	What is the average daily consumption of alcohol?	<input type="text"/>	<input type="text"/>	
				Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes <input type="checkbox"/> Number smoked <input type="checkbox"/>

2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father	57			
Mother	53			
Brother / Sister	29			
Brother / Sister	26			
Brother / Sister	20			

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 for the use of 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

09/10/2020



MEDICAL FITNESS CERTIFICATE MEDICAL REPORT

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

3. SUMMARY OF MEDICAL HISTORY OF MR. / MRS. JOSUP SAKIT PARULIAH SIMBA

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 checked="" type="checkbox"/>	8. Endocrine disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Nose, mouth or throat trouble	<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 checked="" type="checkbox"/>	10. Fistula / Appendicitis / Varicocele	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Frequent headaches / Fainting	<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 checked="" type="checkbox"/>	12. Skin disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Hypertension	<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 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)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Height: 164 cm	Weight: 72 Kg
b) Please describe general appearance and build.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	BMI: 26.76 /m ²	Waist Circumference: 94 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Are there any scars of material significance?	<input type="checkbox"/>	<input checked="" 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"/>	<input checked="" type="checkbox"/>		
b) Is there any irregularity of rhythm?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is there any abnormality in the arterial pulse?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Are there any varicose veins?	<input type="checkbox"/>	<input checked="" 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: 114/89 mmHg	Pulse Rate: 63/min
10. Respiratory System					
a) Is there any abnormality in the shape and development of the chest?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Are there any abnormal physical signs in the lungs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
11. Genito / Urinary & Digestive System					
a) Is the urine test abnormal?	<input type="checkbox"/>	<input checked="" 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"/>	<input checked="" type="checkbox"/>		
c) Is a hernia present	<input type="checkbox"/>	<input checked="" 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"/>	<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"/>	<input checked="" type="checkbox"/>		
b) Is there anything to suggest a tendency to psychiatric disorder?	<input type="checkbox"/>	<input checked="" 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"/>	<input checked="" type="checkbox"/>		
Vision		Far Vision		Near Vision	
Uncorrected	OD 4/6 OS 4/6	OD 3/1 OS 3/1	Color Vision Adequate <input checked="" type="checkbox"/>		
Corrected	OD _____ OS _____	OD _____ OS _____	Defective		

Remarks:



MEDICAL FITNESS CERTIFICATE MEDICAL REPORT

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

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 (****) WITHIN NORMAL LIMIT
2. ECG Report NORMAL RESTING ECG
3. Audiogram Report NORMAL
4. Spirometry Report HA

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

- 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):

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

- 8. HIV Test (*)
9. Tine (Tuberculin test) (*)
10. HBsAg (**) HBsAb (**) HBeAb (**) 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: 07/10/2021

I have examined Mr./Mrs. JOSUA SAKAT P.S and found him/her (tick the box)
FIT for (offshore/onshore) duty [checked] UNFIT for duty [] Pending []

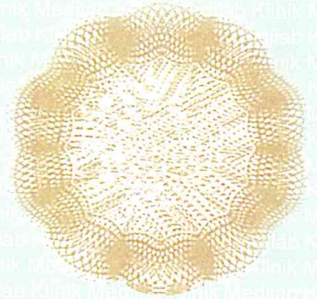


Examining Doctor's Signature Date: 07/10/2021
(Stamp, Signature, Name and address of the Physician)
dr. Rezga Agneia
Examining Physician



Management System
ISO 9001:2015

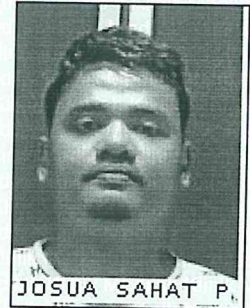
www.tuv.com
ID 9105042627



EYE EXAMINATION REPORT

IDENTIFICATION OF APPLICANT

Applicant's Name : JOSUA SAHAT PARULIAN SINAGA
DOB/Gender/Emp. ID: 3 July 1992 / Male / 19165
Address : CITRA BATAM BLOK C NO 194, BATAM
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



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, 08 October 20

Place, Date of eye examination

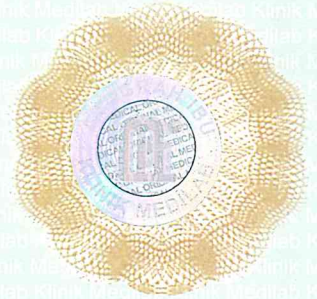


Official Stamp of Medical Practitioner



Management System
ISO 9001:2015

www.tuv.com
ID 9105042627



HEALTH SCREENING REPORT

Preemployment Physical Examination

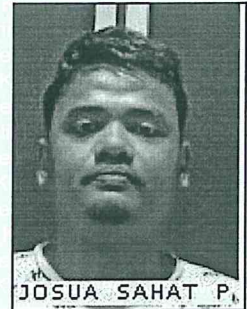
135

CONFIDENTIAL

No. Medical Record : 
00021/002/X/ISP/20

PERSONAL DATA

Name : JOSUA SAHAT PARULIAN SINAGA
 Birthday/Gender/Emp. ID : 3 July 1992 / Male / 19165
 Father's Name : SIHAR SINAGA
 Address : CITRA BATAM BLOK C NO 194, BATAM
 Occupation : 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	: 72 Kg			3. Cardiovascular System			
BMI	: 26.76			a. Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
				Systolic / Diastolic	: 114 / 89 mm Hg		
				Pulse	: 63 / min		
1. Vision				b. Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
a. Distant Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>		c. Varicose Veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
(Should be at least 6/12 in both eyes with or without glasses)				4. Respiratory System	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b. Near Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>		5. Skin-Chronic Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
(Should be at least J2 in both eyes with or without glasses)				6. Abdomen	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c. Colour Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>		7. Locomotor/Neurological	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
d. Any Organic Eye Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>		8. Endocrine disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Hearing	<input type="checkbox"/>	<input checked="" type="checkbox"/>		9. Mental State	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
(Unable to hear ordinary conversation at 2 m)							

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 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: 94 cm, Lab: Alkaline Phosphatase R74.9 139 U/L MIE, HDL E78.4 49 mg/dl BHR, Cholesterol Ratio E78 3.6 AR, Blood Count: Monocytosis D72.821 8.2%

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, Diet to Raise HDL Cholesterol

Authentic Signature

Date of Exam : 8 October 2020




DR. REZGA AGNELA VALBETRI



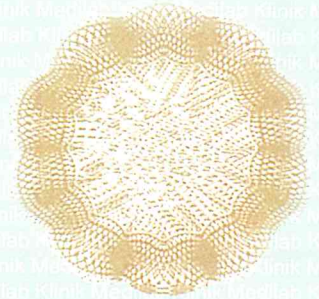
Management System
ISO 9001:2015

www.tuv.com
ID 9105042627

M^oKLINIK 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



HEALTH SCREENING REPORT

Preemployment Physical Examination

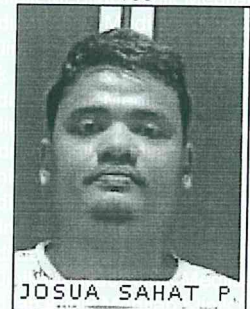
CONFIDENTIAL

No. Medical Record : 
00021/002/X/ISP/20

135

PERSONAL DATA

Name : JOSUA SAHAT PARULIAN SINAGA
Birthday/Gender/Emp. ID : 3 July 1992 / Male / 19165
Father's Name : SIHAR SINAGA
Address : CITRA BATAM BLOK C NO 194, BATAM
Occupation : 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	14.3	gr/dl	M: 13.2 - 17.3	F: 11.7 - 15.5	
WBC	9.6	10 ³ /mm ³	M: 3.8 - 10.6	F: 3.6 - 11.0	
RBC	4.75	10 ⁶ /mm ³	M: 4.4 - 5.9	F: 3.8 - 5.2	
ESR	8	mm/hr	M: 0 - 10	F: 0 - 20	
HCT	42.0	%	M: 40 - 52	F: 35 - 47	
PLT	323	10 ³ /mm ³	150 - 440		
Differential Count					
- LYM	30.6	%	25 - 40		
- MON	* 8.2	%	2 - 8		
- GRA	61.2	%	43 - 76		
Indicator of Infection					
- Neutrofil Lymphocyte Ratio (NLR)	2	%	> 3.13 Cautious	6 - 9 Suspicious	> 9 Perilous
- Absolute Lymphocyte Count (ALC)	2938	%	< 1500 Cautious	< 1100 Suspicious	< 500 Perilous

URINE FEME

Macroscopy	Result	Microscopy	Result
- pH	5	- WBC/HPF	Occ/HPF
- Specific Gravity	1.010	- 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.

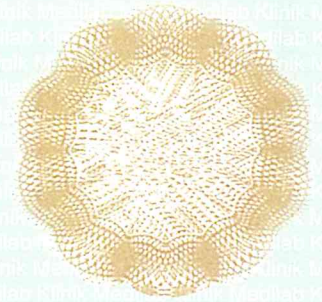
Date of Exam : 8 October 2020



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




Management System
ISO 9001:2015
www.tuv.com
ID 9105042627



HEALTH SCREENING REPORT

Preemployment Physical Examination

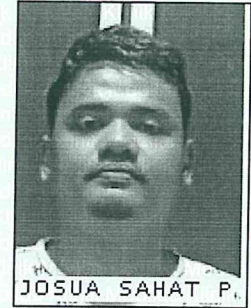
CONFIDENTIAL

No. Medical Record : 
00021/002/X/ISP/20

135

PERSONAL DATA

Name : JOSUA SAHAT PARULIAN SINAGA
 Birthday/Gender/Emp. ID : 3 July 1992 / Male / 19165
 Father's Name : SIHAR SINAGA
 Address : CITRA BATAM BLOK C NO 194, BATAM
 Occupation : INSPECTOR
 Name of Employer / Recruitment Agency : INSPEKTINDO SINERGI PERSADA, PT
 Address of Employer / Recruitment Agency : KAWASAN INDUSTRI SEKUPANG KAVLING.13, BATAM



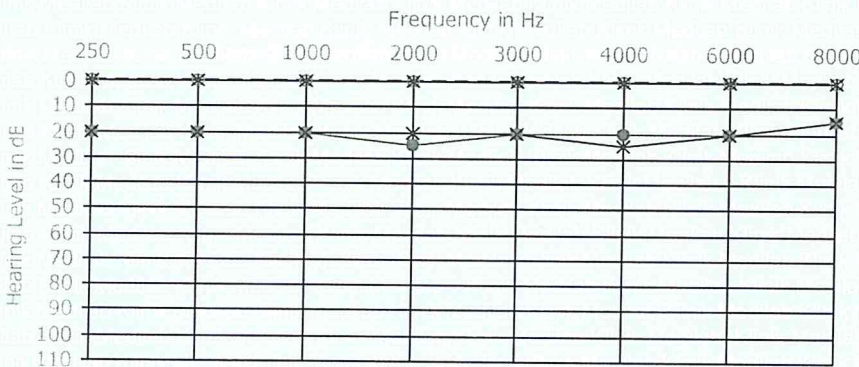
AUDIOMETRY REPORT

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 : -5.63 %
L : -5.63 %
Hearing Handicap : -5.625 %
- Not a Noise Induced Hearing Loss

Date of Exam : 8 October 2020

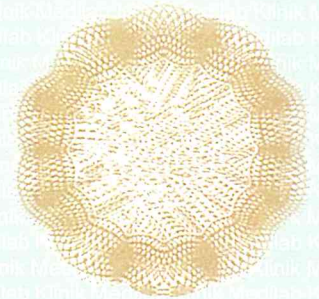


>> Computer Generated Report, No Signature Required. <<



Management System
ISO 9001:2015

www.tuv.com
ID 9105042627



HEALTH SCREENING REPORT

Preemployment Physical Examination

CONFIDENTIAL

No. Medical Record : 
00021/002/X/ISP/20

135

PERSONAL DATA

Name : JOSUA SAHAT PARULIAN SINAGA
Birthday/Gender/Emp. ID : 3 July 1992 / Male / 19165
Father's Name : SIHAR SINAGA
Address : CITRA BATAM BLOK C NO 194, BATAM
Occupation : 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	:	0.8 mg/dl	0.3 - 1.1
Direct Bilirubin	:	0.2 mg/dl	0.1 - 0.4
Indirect Bilirubin	:	0.6 mg/dl	0.2 - 0.7
Alkaline Phosphatase	:*	139 U/L	30 - 120
SGOT	:	15 U/L	M: <= 35 F: <= 31
SGPT	:	30 U/L	M: <= 45 F: <= 34
Gamma GT	:	45 U/L	M: <= 49 F: <= 32
LIPID PROFILE TEST			
Total Cholesterol	:	174 mg/dl	<= 200
HDL - Cholesterol	:	49 mg/dl	M: > 35 F: > 45
LDL - Cholesterol	:	101 mg/dl	50 - 140
Triglycerida	:	120 mg/dl	<= 204
Ratio Cholesterol (Total Chol : HDL)	:*	3.6	M: < 3.4 F: < 3.3
BLOOD SUGAR TEST			
Nuchter	:	91 mg/dl	< 100
RENAL FUNCTION TEST			
Ureum	:	21 mg/dl	17 - 43
SEROLOGI			
TPHA	:	Non Reactive	Non Reactive
URINE			
Cannabinoid	:	Negative	Negative
Methamphetamine	:	Negative	Negative
Opiates	:	Negative	Negative
Cocain	:	Negative	Negative
Benzodiazepine	:	Negative	Negative

Date of Exam : 8 October 2020



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



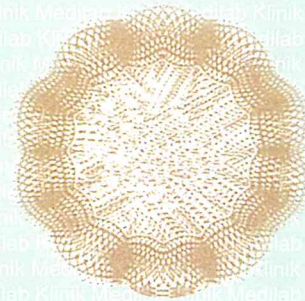
Management System
ISO 9001:2015

www.tuv.com
ID 9105402627



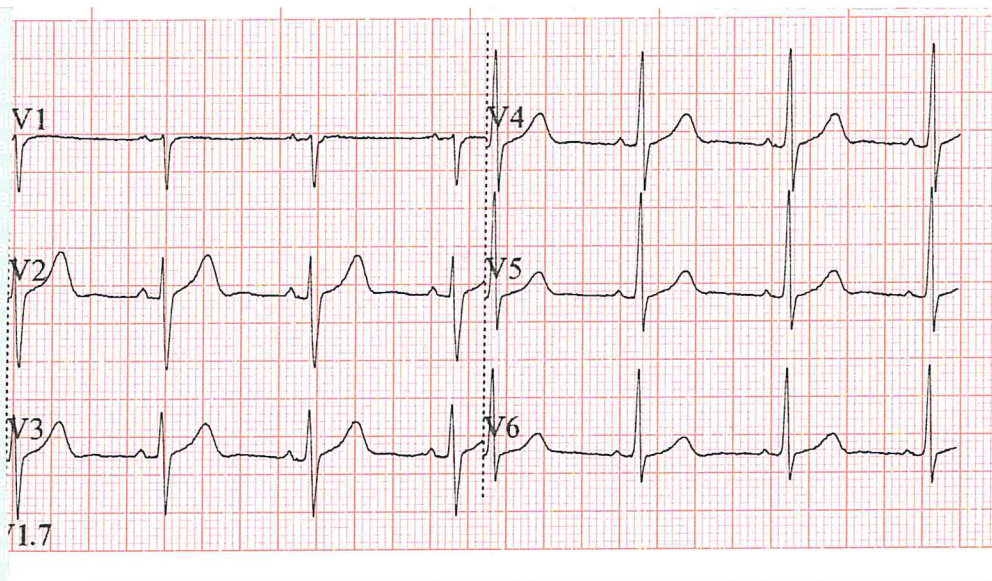
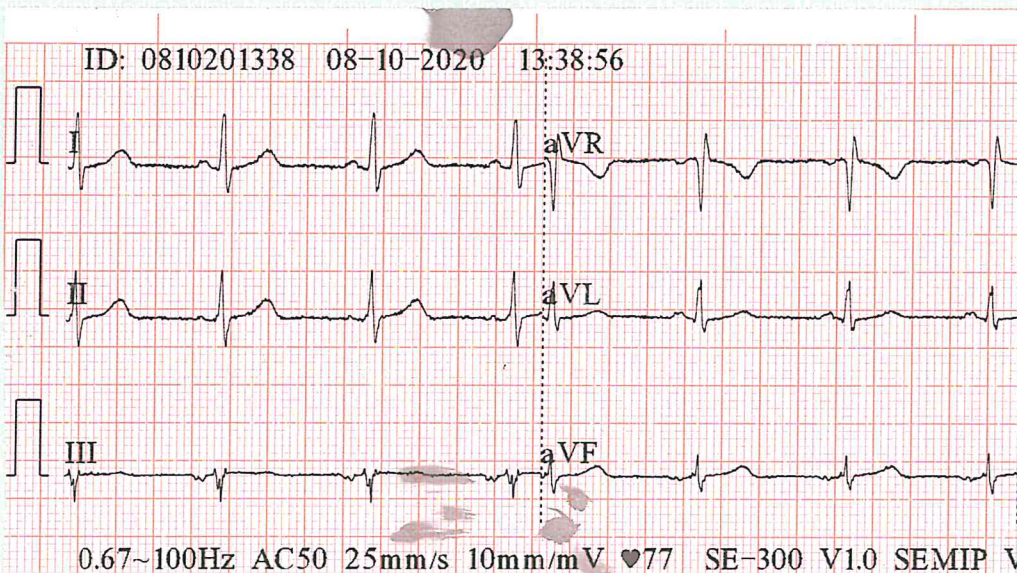
PUSAT PEMERIKSAAN KESEHATAN TENAGA KERJA

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 : JOSUA SAHAT PARULIAN SINAGA
Age : 28 Years
Gender : Male
Place/Date : BATAM/08 October 2020
Company's Name : INSPEKTINDO SINERGI PERSADA, PT



CONCLUSION : Normal Resting ECG

ADVICE :

EXAMINER :

dr. REZGA AGNELA VALBETRI
Examining Physician