Republic of the Philippines
Department of Labor and Employment
Regional Office No. 8

ANNUAL MEDICAL REPORT FORM

For Period January 1, _____ to December 31, _____

1. Name of Establishment:_____

2. Address:_____

3. Name of Owner/ Manager:_____

4. Nature of Business & Product/ Service (Ex. Manufacturing – textile)_____
_____

5. Total Number of Employee:_____ Number of Shift:_____

6. Number Distribution of Employee as to nature/workplace, sex & workship:

	office	Product/Shop		
		1st Shift	2nd Shift	3rd Shift
Male	:	_____	_____	_____
Female:	_____	_____	_____	_____
Total:	_____	_____	_____	_____

7. Preventive Occupational Health Service: (Check or Cross)

   a. Occupational health service is organized / provided by:

      ( ) the establishment / undertaking
      ( ) government authority / institution
      ( ) other bodies / group / institution (specify)_____
      _____

   b. Occupational health services as described under number 7a above, is organized / provided as a service :

      ( ) solely for the workers of the establishment / undertakings
      ( ) common to a number of establishment / undertakings

c. The employer engages the services of :

( ) Occupational health practitioner
Name: _____
Address: _____
( ) Occupational health physician
Name: _____
Address: _____
( ) Occupational health dentist
Name: _____
Address: _____
( ) Occupational health nurse
Name: _____
Address: _____

d. The occupational health physician/practitioner/nurse/personnel conducts an inspection of the work place:

( ) once every month
( ) once every two (2) months
( ) once every three (3) months
( ) once every six (6) months
( ) other details: _____
_____

8. Emergency Occupational Health Services:

a. The employer provides a treatment room/medical clinic in the work place with medicines and facilities

( ) Yes _____ ( ) No _____
( ) others, please specify _____
_____

b. Schedule of attendance in the work place:

		Work shift
Occupational health physician	:_____	hrs./day_____
Occupational health dentist	:_____	hrs/day _____

c. Schedule of attendance of full time first aider

( ) 1st work shift
( )2nd work shift
( ) 3rd work shift

d. The following occupational health personal of this establishment have under gone training in occupation health and safety/first aid :

( ) Occupational health physician
( ) Occupation health dentist
( ) Occupation health nurse
( ) first - aider
( ) Others, please specify_____

9. Occupational Health Services

a. The occupational health personnel of this establishment regular appraisal of the sanitation system in the workplace:

( ) Yes ( ) No

b. Number of workers who underwent the following medical examinations:

	Physical Exam	X-rays	Urinalysis
1. Pre-placement	_____		
2. Periodic			
3. Return-to –work	_____		
4. Transfer			
5. Special			
6. Separation	_____		

	Stool Exam	Blood Test	ECG	Others
1. Pre-placement	_____			
2. Periodic				
3. Return-to-work	_____			
4. Transfer				
5. Special				
6. Separation	_____			

10. Report of Diseases

a. Number of consultations/treatments for the following diseases:

	Male	Female	Total No. Of Cases
Skin:			
( ) Allergy	_____	_____	_____
( ) Dermatoses	_____	_____	_____
( ) Infection as folliculitis abscess/paronychia	_____	_____	_____
( ) Others	_____	_____	_____
Head:			
( ) Tension/headache	_____	_____	_____
( ) Others	_____	_____	_____
Eyes:			
( ) Error of refraction	_____	_____	_____
( ) Bacterial/Viral conjunctivities	_____	_____	_____
( ) Cataract	_____	_____	_____
( ) Others	_____	_____	_____
Mouth & ENT:			
( ) Gingivitis	_____	_____	_____
( ) Herpes Labiales/ nasalis	_____	_____	_____
( ) Otitis Media Externa	_____	_____	_____
( ) Deafness	_____	_____	_____
( ) Meniere"s Syndrome /Vertigo	_____	_____	_____
( ) Rhinitis/Colds	_____	_____	_____
( ) Nasal Polyps	_____	_____	_____
( ) Sinusitis	_____	_____	_____
( ) Tonsilio			

pharyngitis	_____	_____	_____
( ) Laryngitis	_____	_____	_____
( ) Others	_____	_____	_____

Respiratory:

( ) Bronchitis	_____	_____	_____
( ) Bronchial/Asthma	_____	_____	_____
( ) Pneumonia	_____	_____	_____
( ) Tuberculosis	_____	_____	_____
( ) Pneumoconiosis	_____	_____	_____
( ) Others	_____	_____	_____

Heart and Blood Vessel:

( ) Hypertension	_____	_____	_____
( ) Hypotension	_____	_____	_____
( ) Angina Pectoris	_____	_____	_____
( ) Myocardial Infraction	_____	_____	_____
( ) Vascular disturbances in extremities due to continuous vibration	_____	_____	_____
( ) Others	_____	_____	_____

Gastrointestinal:

( ) Casroenteritis/ Diarrhea	_____	_____	_____
( ) Amoebiasis	_____	_____	_____
( ) Gastritis/ Hyperacidity	_____	_____	_____
( ) Appendicitis	_____	_____	_____
( ) Infectious Hepatitis	_____	_____	_____

( ) Liver Cirrhosis _____ _____ _____
( ) Hepatic Abscess _____ _____ _____
( ) Cancer (Hepatic/ Gastric) _____ _____ _____
( ) Ulcer _____ _____ _____
( ) Others _____ _____ _____

Genito Urinary:

( ) Urinary Tract infection _____ _____ _____
( ) Stones _____ _____ _____
( ) Cancer _____ _____ _____
( ) Others _____ _____ _____

Reproductive:

( ) Dysmenorrhea _____ _____ _____
( ) Isfection (Cervicitive) (Vaginitis) _____ _____ _____
( ) Abortion (Spontaneus) _____ _____ _____
(threatened) _____ _____ _____
( ) Hyperremesis Gravidarum _____ _____ _____
( ) Uterine Tumors _____ _____ _____
( ) Cervical Polyp/ Cancer _____ _____ _____

12. Immunization Program (Indicate number immunized)

Nature	Male	Female	Total No. Of Cases
Tetanus Toxoid	Injection	_____	_____
Tetanus Antioxin	Injection	_____	_____
Tetanus Globulin	Injection	_____	_____
Hepatitis B Vaccine	_____	_____	_____
Rabies Vaccine	_____	_____	_____
Others (Please Specify)	_____	_____	_____

13. Keeping of Medical Records of Workers (Please Check)

( ) Done ( ) Not Done

14. Health Education and Counseling by Health and Safety Personnel: (Please Check one or more)

( ) done individual as each worker comes to the clinic for consultation.
( ) done in organized group discussions/seminars.
( ) done with the use of visual displays and/or promotional materials, leaflets, etc.

15. Other Health Programs (Please Check)

Kinds of Program	Seminars	Use of Visual id/Materials	Counseling
Nutrition Program	( )	( )	( )
Material and Child Care Program	( )	( )	( )
Family Planning Program	( )	( )	( )
Mental Health Activities	( )	( )	( )
Personal Health Maintenance	( )	( )	( )

Physical Fitness Program: (Please Check)

Sport Activities	( ) Yes	( ) No
Others (Please Check)	( ) Yes	( ) No

16. Hazard in the workplace : (Please check and give details of the substance)

	Substance and/or sources	Number of workers exposed
a. Chemical Hazard:		
b.		
( ) Dust (Ex. Silica dust)		_____
( ) Liquid (Ex. Mercury)		_____
( ) Mist/fumes/vapors (Ex. mist from paint spraying)		_____
( ) Gas (Ex. CO, H2S)		_____
( ) Others (please specify) (Ex. solvents)	_____	_____

Physical Hazards

( ) Noise
( ) Temperature/humidity
( ) Pressure
( ) Illumination
( ) Radiation/ultraviolet/microwave
( ) Vibration
( ) Others (Please specify)

c. Biological hazard:

( ) Viral	_____	_____
( ) Bacterial	_____	_____
( ) Fungal	_____	_____
( ) Parasitic	_____	_____
( ) Others, specify	_____	_____

d. Ergonomic Stress:

( ) Exhausting physical work	_____	_____
( ) Prolonged standing	_____	_____
( ) Low back pain	_____	_____
( ) Unfavorable work posture	_____	_____
( ) Static/monotonous work	_____	_____
( ) Others, specify	_____	_____

Submitted by:

_____ _____
Medical Personnel/Title Date

Noted by:

_____
Employer