DOLE/BWC/HSD/OH-47-A

Republic of the Philippines

DEPARTMENT OF LABOR AND EMPLOYMENT

Bureau of Working Conditions

ANNUAL MEDICAL REPORT FORM

For Period January 01,_____ to December 31,_____

1. Name of Establishment: _____
2. Address:_____
3. Name of Owner/Manager: _____
4. Nature of Business and Products/Services (Ex. Manufacturing, Textile _____
5. Total Numbers of Employees:_____ Number of Shifts:_____
6. Number Distribution of Employees as to nature/workplace, sex and work shift:

	Office	**Production/Shop**		
		1st Shift	**2nd Shift**	**3rd Shift**
Male: _____		_____	_____	_____
Female: _____		_____	_____	_____
Total: _____		_____	_____	_____

7. Preventive Occupational Health Services: (Check or Cross)
   a Occupational Health Services is organized/provided by:
   ( ) The establishment /undertaking
   ( ) Government authority institution
   ( ) Other bodies/groups/institution (specify) _____

   b Occupational health services as described under number 7a above is organizes/provided as a services:
   ( ) Solely for the workers of the establishment/undertaking
   ( ) Common to any number of establishment/undertakings _____

   c The employer engages the service 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 conduct an inspection of the workplace:
   ( ) Once every month ( ) Once every three (3) months
   ( ) Once every two (2) months ( ) Once every six (6) months
   ( ) Other details _____
8. Emergency Occupational Health Services:
   a. The employer provides a treatment room/medial clinic in the workplace with medicines and facilities:
   ( ) yes_____ ( ) No
   ( ) others, please specify _____

   b. Schedule of attendance in the workplace:

Workshift

Occupational Health Physician: _____hrs./day _____
Occupational Health Dentist: _____hrs./day _____
Occupational Health Practitioner: _____hrs./day _____
Occupational Health Nurse: _____ hrs./day _____

c. Schedule of attendance of full time first aider
( ) 1st workshift
( ) 2nd workshift
( ) 3rd workshift

d. The following occupational health personnel of this establishment have undergone training in occupational health and safety/first aid:
( ) occupational health physician
( ) occupational health dentist
( ) occupational health nurse
( ) first-aider
( ) others, please specify: _____

9. Occupational Health Services:

a. The occupational health personnel of this establishment conducts regular appraisal of the sanitation system in the workplace:
( ) yes ( ) no

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

	Physical Exams	**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	_____	_____	_____
( ) dermatomes	_____	_____	_____
( ) infections as folliculities	_____	_____	_____
abscess/paro nychia	_____	_____	_____
( ) Others	_____	_____	_____
Head:			
( ) tension headache	_____	_____	_____
( ) others	_____	_____	_____
Eyes:			
( ) error of refraction	_____	_____	_____
( ) bacteria/Viral conjunctivitis	_____	_____	_____
( ) cataract	_____	_____	_____
( ) others	_____	_____	_____
Mouth & ENT:			
( ) Gingivitis	_____	_____	_____

	Male	Female	Total No. Of Cases
( ) Herpes liables/nasal's			
( ) Otitis/Media External			
( ) Deafness			
( ) Meniere's syndrome Vertigo			
( ) Rhinitis/Cold			
( ) Nasal Polyps			
( ) Sinusitis			
( ) Tonsillopharynngitis			
( ) Laryngitis			
( ) Others			
Respiratory:			
( ) Bronchitis			
( ) Pneumonia			
( ) Tuberculosis			
( ) Pneumoconiosis			
( ) Others			
Hearth & Blood Vessels:			
( ) Hypertension			
( ) Hypertension			
( ) Angina Pectoris			
( ) Myocardial Infarction			
( ) Vascular Disturbance in extremities due to continues Vibration			
( ) Others			
Gastrointestinal:			
( ) Gastroenteritis			
( ) 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			
( ) Infection (Cervicitis)			
(Vaginitis)			
( ) Abortion (Spontaneous)			
(threatened)			
( ) Hyperemesis Gravidarum			
( ) Uterine Tumors			
( ) Cervical Polyp/Cancer			
( ) Ovarian Cyst/Tumors			
( ) Sexually-Transmitted diseases			

	Male	Female	Total No. Of Cases
( ) Hernia (Inguinal)			
(Femoral)			
( ) Others			
Neuromuscular/Skeleal/Joints:			
( ) Peripheral Neuritis			
( ) Torticollis			
( ) Arthritis			
( ) Others			
Lymphatic and Circulatory			
( ) Anemia			
( ) Leukemia			
( ) Cerebrovascular			
( ) Lymphadenitis			
( ) Lymphoma			
Infectious Diseases:			
( ) Influenza			
( ) Typhoid/Paratyphoid Fever			
( ) Cholera			
( ) Measles			
( ) Mumps			
( ) Tetanus			
( ) Malaria			
( ) Schitosomiasis			
( ) Herpes Zoster			
( ) Chicken Pox			
( ) German Measles			
( ) Rabies			
( ) Others			
Diseases Due to Physical Environment:			
a. **Diseases Due to Noise and Vibration**			
( ) Deafness (noise induced)			
( ) White fingers disease			
( ) Musculo-skeletal disturbances			
( ) Fatigue			
b. **Diseases Due to Temperature and** Humidity Abnormalities:			
Hot temperature			
( ) Heat strokes			
( ) Heat cramps			
( ) dehydration			
( ) neat exhaustion			
( ) others			
Cold Temperature			
( ) Childblain			
( ) Frost bite			
( ) Immersion foot			
( ) General Hypothermia			
( ) Others			
c. Diseases due to Pressure Abnormalities:			
( ) Decompression Sickness			
( ) air embolism			
( ) Bends Disease			
( ) Barotraumas			
( ) Hypoxia			
( ) Altitude sickness			

	Male	Female Total	No. of Cases
d. Diseases due to Radiation:			
( ) cataracts	_____	_____	_____
( ) keratitis	_____	_____	_____
( ) burns	_____	_____	_____
( ) radiation-related cancer	_____	_____	_____
TOTAL NUMBER	_____	_____	_____

11. **Report of Occupational Accidents/injuries**

Nature	Male	Female	Number of Case
Confusion, bruises, Hematoma	_____	_____	_____
Abrasions	_____	_____	_____
Cuts, lacerations, Punctures	_____	_____	_____
Concussion	_____	_____	_____
Avulsion	_____	_____	_____
Amputation, loss of Body parts	_____	_____	_____
Crushing	_____	_____	_____
Injuries Spinal	_____	_____	_____
Injuries Cranial	_____	_____	_____
Injuries Sprains	_____	_____	_____
Dislocation/fractures	_____	_____	_____
Burns	_____	_____	_____

12. **Immunization Program (indicate number immunized)**

Tetanus Toxiod Injection	_____	_____	_____
Tetanus Antitoxin 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 done or more)

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

15. Other Health Programs (Please Check)

Kinds of Program	Seminar	Use of Visual Aid/Material	Counseling
Nutrition Program			
Maternal and Child Care Program			
Family Planning Program			
Mental Health Activities			
Personal Health Maintenance			

Physical Fitness Program: (Please Check)

Sports Activities ( ) Yes ( ) No
Others (Please specify) ( ) Yes ( ) No

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

		Substance and/or	Number of Workers
a.	**Chemical Hazards:**		
	( ) dust (Ex. Silica dust)	_____	_____
	( ) liquids (Ex. Mercury)	_____	_____
	( ) mist/fumes/vapors (Ex. Mist from pint spraying)	_____	_____
	( ) gas (Ex. CO, H2S)	_____	_____
	( ) others (Please Specify) (Ex. Solvent)	_____	_____
b.	**Physical Hazards**		
	( ) Noise	_____	_____
	( ) temperature/humidity	_____	_____
	( ) pressure	_____	_____
	( ) illuminations	_____	_____
	( ) radiations/ultraviolet microwave	_____	_____
	( ) vibrations	_____	_____
	( ) others (Please specify)	_____	_____
c.	**Biological Hazards:**		
	( ) Viral	_____	_____
	( ) Bacterial	_____	_____
	( ) Fungal	_____	_____
	( ) Parasitic	_____	_____
	( ) Others (please specify	_____	_____
d.	**Ergonomic Stress:**		
	( ) Exhausting Physical	_____	_____
	( ) Prolong Standing	_____	_____
	( ) Excessive Mental Effort	_____	_____
	( ) Unfavorable Work Posture	_____	_____
	( ) Static/monotonous work	_____	_____
	( ) Others, specify	_____	_____

Submitted by:

_____ _____
Medical/Personnel/Title Date

Noted by:

_____
Employer

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