

Republic of the Philippines
DEPARTMENT OF LABOR AND EMPLOYMENT
 Bureau of Working Conditions

REPUBLIC OF THE PHILIPPINES
 DEPARTMENT OF LABOR AND EMPLOYMENT
 REGIONAL OFFICE NO. 1
 SAN FERNANDO, LA UNION
 (MSD) RECORDS UNIT

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ANNUAL MEDICAL REPORT FORM

BY: _____

For the Period of January 1, 2023 to December 31, 2023

1. Name of Establishment: PORO POINT MANAGEMENT CORPORATION
2. Address: GOV. JOAQUIN L. ORTEGA AVE. PORO POINT, CSF, LA UNION
3. Name of Owner/Manager: _____
4. Nature of Business and Product / Service (Ex. Manufacturing, Textile)
ESTATE MANAGEMENT
5. Total Number of Employees: 59 Number of Shifts: 3
6. Number Distribution of Employees as to nature/workplace, sex and work shift:
 Office: _____ Production/Shop _____

	No. of Employees	1st Shift ¹	2nd Shift ²	3rd Shift ³
Male :	38	32	5	1
Female :	21	21	0	0
Total :	59	53	5	1

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 7a above, is organized/provided as a service:
 - solely for the workers of the establishment/undertaking
 - Common to a number of establishments/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: JOANNE P. MACAGBA/NURSE
 Address: GOV. JOAQUIN L. ORTEGA AVE. PORO POINT, CSF, LA UNION
 - d. The occupational health physician/practitioner/nurse/personnel conducts an inspection for 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/medical clinic in the workplace with medicines and facilities:
 - yes CLINIC No _____
 - others, please specify FIRST AD KITS, MEDICINES

b. Schedule of attendance in the workplace:

¹ 1st shift pertains to employees rendering duty from 8am to 5pm.
² 2nd shift pertains to employees rendering duty from 6am to 6pm.
³ 3rd shift pertains to employees rendering duty from 4pm to 8am.

		Work shift
Occupational health physician	: _____	hrs./day _____
Occupational health dentist	: _____	hrs./day _____
Occupational health practitioner	: _____	hrs./day _____
Occupational health nurse	: <u>8</u>	hrs./day <u>1ST</u>

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	<u>5</u>	<u>5</u>	<u>5</u>
2. Periodic	_____	_____	_____
3. Return-to-work	_____	_____	_____
4. Transfer	_____	_____	_____
5. Special	_____	_____	_____
6. Separation	_____	_____	_____

	Stool Exam	Blood Test	ECG	Others (drug test)
1. Pre-placement	<u>5</u>	<u>5</u>	_____	<u>5</u>
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 Number of Cases
Skin:			
<input checked="" type="checkbox"/> Allergy	<u>5</u>	<u>3</u>	<u>8</u>
<input checked="" type="checkbox"/> Dermatoses	_____	<u>1</u>	<u>1</u>
<input type="checkbox"/> Infection as Folliculitis	_____	_____	_____
<input type="checkbox"/> Abscess/paronychia	_____	_____	_____
<input type="checkbox"/> Others (Burn)	_____	_____	_____
Head:			
<input checked="" type="checkbox"/> tension headache	<u>3</u>	<u>3</u>	<u>6</u>
<input checked="" type="checkbox"/> others (Migraine Headache)	<u>2</u>	<u>8</u>	<u>10</u>
Eyes:			
<input checked="" type="checkbox"/> Error of refraction	<u>2</u>	<u>2</u>	<u>4</u>
<input checked="" type="checkbox"/> Bacterial/Viral Conjunctivitis	<u>2</u>	<u>3</u>	<u>5</u>
<input checked="" type="checkbox"/> Cataract	<u>1</u>	_____	<u>1</u>
<input type="checkbox"/> Others	_____	_____	_____
Mouth & ENT:			
<input type="checkbox"/> Gingivitis	_____	_____	_____
<input type="checkbox"/> Herpes Labiales/ Nasalis	_____	_____	_____
<input type="checkbox"/> Otitis Media/Eterna	_____	_____	_____
<input type="checkbox"/> Deafness	_____	_____	_____
<input type="checkbox"/> Meniere's Syndrome/ Vertigo	_____	_____	_____
<input checked="" type="checkbox"/> Rhinitis/Colds	<u>5</u>	<u>6</u>	<u>11</u>
<input type="checkbox"/> Nasal Polyps	_____	_____	_____

	Male	Total Number Female	of Cases
(X) Sinusitis	<u>1</u>	<u>2</u>	<u>3</u>
(X) Tonsillopharyngitis	<u>1</u>	<u>2</u>	<u>3</u>
() Laryngitis			
(X) Others (TOOTHACHE)	<u>1</u>		<u>1</u>
Respiratory:			
(X) Bronchitis		<u>1</u>	<u>1</u>
(X) Bronchial Asthma		<u>1</u>	<u>1</u>
(X) Pneumonia	<u>1</u>	<u>1</u>	<u>2</u>
() Tuberculosis			
() Pneumoconiosis			
(X) Others (Cough)	<u>2</u>	<u>2</u>	<u>4</u>
Heart and Blood Vessel:			
(X) Hypertension	<u>8</u>	<u>3</u>	<u>11</u>
() Hypotension		<u>1</u>	<u>1</u>
(X) Angina Pectoris		<u>1</u>	<u>1</u>
() Myocardial Infarction			
() Vascular disturbances In extremities due to Continuous vibration			
() Others			
Gastrointestinal:			
(X) Gastroenteritis/ Diarrhea	<u>1</u>	<u>2</u>	<u>3</u>
(X) Amoebiasis		<u>1</u>	<u>1</u>
(X) Gastritis/Hyperacidity	<u>2</u>	<u>4</u>	<u>6</u>
() Appendicitis			
() Infectious Hepatitis			
() Liver Cirrhosis			
() Hepatic Abscess			
() Cancer (Hepatic/Gastric)			
() Ulcer			
(X) Others (GERD)		<u>1</u>	<u>1</u>
Genito Urinary:			
(X) Urinary Tract Infection		<u>2</u>	<u>2</u>
() Stones			
() Cancers			
() Others			
Reproductive:			
(X) Dysmenorrhea		<u>5</u>	<u>5</u>
() Infection (Cervicitis) (Vaginitis)			
() Abortion (Spontaneous) (Threatened)			
() Hyperemesis Gravidarum			
() Urine Tumors			
() Cervical Polyp/Cancer			
() Ovarian Cyst/Tumors			
() Sexually-Transmitted Diseases			
() Hernia (Inguinal) (Femoral)			
() Others			
Neuromuscular/Skeletal/Joints:			
() Peripheral Neuritis			
() Torticollis			
(X) Arthritis	<u>7</u>		<u>7</u>
(X) Others (SCIATICA)		<u>1</u>	<u>1</u>

	Male	Female	Total Number of Cases
Lymphatics and Circulatory:			
<input checked="" type="checkbox"/> Anemia		2	2
<input type="checkbox"/> Leukemia			
<input type="checkbox"/> Cerebrovascular Accidents			
<input type="checkbox"/> Lymphadenitis			
<input type="checkbox"/> Lymphoma			
Infectious Diseases:			
<input checked="" type="checkbox"/> Influenza	3	2	5
<input type="checkbox"/> Typhoid/Paratyphoid Fever			
<input type="checkbox"/> Cholera			
<input type="checkbox"/> Measles			
<input type="checkbox"/> Tetanus			
<input type="checkbox"/> Malaria			
<input type="checkbox"/> Schistosomiasis			
<input type="checkbox"/> Herpes Zoster			
<input type="checkbox"/> Chicken Pox			
<input type="checkbox"/> German Measles			
<input checked="" type="checkbox"/> Rabies	1		1
<input type="checkbox"/> Others			
Diseases Due to Physical Environment:			
a) Disease Due to Noise and Vibration			
<input type="checkbox"/> Deafness (noise induced)			
<input type="checkbox"/> White Fingers disease			
<input type="checkbox"/> Musculo-skeletal disturbances			
<input checked="" type="checkbox"/> Fatigue	3		3
b) Diseases Due to Temperature and Humidity Abnormalities:			
Hot Temperature			
<input type="checkbox"/> heat strokes			
<input checked="" type="checkbox"/> heat cramps	1		1
<input type="checkbox"/> dehydration			
<input checked="" type="checkbox"/> heat exhaustion	1		1
<input type="checkbox"/> Others			
Cold Temperature			
<input type="checkbox"/> chilblain			
<input type="checkbox"/> frost bite			
<input type="checkbox"/> immersion foot			
<input type="checkbox"/> general hypothermia			
<input type="checkbox"/> Others			
c) Diseases Due to Pressure Abnormalities:			
<input type="checkbox"/> Decompression Sickness:			
<input type="checkbox"/> Air embolism			
<input type="checkbox"/> bends diseases			
<input type="checkbox"/> Barotrauma			
<input type="checkbox"/> Hypoxia			
<input type="checkbox"/> altitude sickness			
d) Diseases Due to Radiation			
<input type="checkbox"/> Cataracts			
<input type="checkbox"/> keratitis			
<input type="checkbox"/> burns			
<input type="checkbox"/> radiation-related cancers			
TOTAL NUMBER	53	60	113

11. Report of occupational Accidents/Injuries

Nature	Male	Female	Total Number of Cases
Contusion, bruises, hematoma	_____	_____	_____
Abrasions	<u>1</u>	_____	<u>1</u>
Cuts, Lacerations, punctures	<u>2</u>	_____	<u>2</u>
Concussion	_____	_____	_____
Avulsion	_____	_____	_____
Amputation, loss of body parts	_____	_____	_____
Crushing Injuries	_____	_____	_____
Spinal Injuries	_____	_____	_____
Cranial Injuries	_____	_____	_____
Sprains	_____	<u>1</u>	<u>1</u>
Dislocation/Fractures	_____	_____	_____
Burns	_____	_____	_____

12. Immunization Program (indicate number immunized)

	Male	Female	Total Number of Cases
Tetanus Toxoid Injection	_____	_____	_____
Tetanus Antitoxin Injection	_____	_____	_____
Tetanus Globulin Injection	_____	_____	_____
Hepatitis B Vaccine	_____	_____	_____
Rabies B Vaccine	_____	_____	_____
Others (please specify)	_____	_____	_____

13. Keeping of Medical Records of Workers (Please Check)
 (X) done () not done

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

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

15. Other Health Programs (Please check)

Kinds of Program	Seminar	Use of Visual Aid/Materials	Counseling
Nutrition Program	_____	_____	_____
Maternal and Child Care Program	_____	_____	_____
Mental Health Activities	_____	<u>✓</u>	_____
Personal Health Maintenance	_____	<u>✓</u>	_____

Physical Fitness Program: (Please Check)

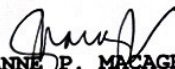
- Sports Activities (X) Yes () No
- Others (Please Specify) () Yes () No

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

a. Chemical Hazards:	Substances and/or Sources	Number of workers exposed
<input type="checkbox"/> () dust (Ex. Silica dust)	_____	_____
<input type="checkbox"/> () liquids (Ex. Mercury)	_____	_____

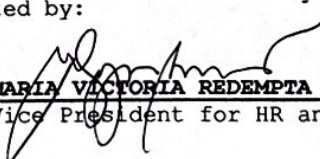
- mist/fumes/vapors
(Ex. Mist from paint Spraying) _____
- gas (Ex. Co, H2S) _____
- others (Please specify)
(Ex. Solvents) _____
- b. Physical Hazards
 - Noise _____
 - temperature/humidity
Pressure _____
 - illumination _____
 - radiation/ultraviolet/
Microwave _____
 - Vibration _____
 - Others (Please specify) _____
- c. Biological Hazards:
 - Viral _____
 - Bacterial _____
 - Fungal _____
 - Parasitic _____
 - Others _____
- d. Ergonomic Stress:
 - Noise _____
 - temperature/humidity
Pressure _____
 - illumination _____
 - radiation/ultraviolet/
Microwave _____
 - Vibration _____
 - Others (Please specify) _____

Submitted by:


JOANNE P. MACAGBA
 Nurse

January 16, 2024
 Date

Noted by:


MARIA VICTORIA REDEMPTA DE GUZMAN-SORIANO
 Vice President for HR and Administration