

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

JAN 26 2022

ANNUAL MEDICAL REPORT FORM

For the Period of January 1, 2021 to December 31, 2021

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: 57 Number
6. Number of Shifts: 3
7. Number Distribution of Employees as to nature/workplace, sex and workshift:
Office: _____ Production/Shop _____

| | No. of Employees | 1st Shift ¹ | 2nd Shift ² | 3rd Shift ³ |
|----------|------------------|------------------------|------------------------|------------------------|
| Male : | <u>37</u> | <u>31</u> | <u>5</u> | <u>1</u> |
| Female : | <u>20</u> | <u>20</u> | <u>0</u> | <u>0</u> |
| Total : | <u>57</u> | <u>51</u> | <u>5</u> | <u>1</u> |

8. 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:
(X) once every month () once every three (3) months
() once every two (2) months () once every six (6) months
() other details _____
9. Emergency Occupational Health Services:
 - a. The employer provides a treatment room/medical clinic in the workplace with medicines and facilities:
(X) yes MEDICINES () No _____
(X) others, please specify FIRST AID

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

b. Schedule of attendance in the workplace:

| | | 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

- (X) 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
 (X) occupational health nurse
 (X) first-aider
 () others, please specify _____

10. Occupational Health Services:

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

- (X) 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 | _____ | _____ | _____ | _____ |

11. Report of Diseases

a. Number of consultations/treatments for the following diseases

| | Male | Female | Total Number of Cases |
|--------------------------------------------------------|----------|----------|-----------------------|
| Skin: | | | |
| (X) Allergy | <u>3</u> | <u>5</u> | <u>8</u> |
| () Dermatoses | _____ | _____ | _____ |
| () Infection as Folliculitis Abscess/paronychia | _____ | _____ | _____ |
| () Others | _____ | _____ | _____ |
| Head: | | | |
| (X) tension headache | <u>2</u> | <u>2</u> | <u>4</u> |
| (X) others (Migraine headache) | <u>3</u> | <u>6</u> | <u>9</u> |
| Eyes: | | | |
| (X) Error of refraction | <u>2</u> | <u>1</u> | <u>3</u> |
| () Bacterial/Viral Conjunctivitis | _____ | _____ | _____ |
| (X) Cataract | <u>1</u> | _____ | <u>1</u> |
| (X) Others - Blurring of vision | <u>1</u> | _____ | <u>1</u> |
| Mouth & ENT: | | | |
| () Gingivitis | _____ | _____ | _____ |
| () Herpes Labiales/ Nasalis | _____ | _____ | _____ |
| () Otitis Media/Eterna | _____ | _____ | _____ |
| (X) Deafness | <u>1</u> | _____ | <u>1</u> |
| () Meniere's Syndrome/ Vertigo | _____ | _____ | _____ |

| | Male | Female | Total Number Of Cases |
|-------------------------------------------------------------------------------------------------|----------|----------|--------------------------|
| <input checked="" type="checkbox"/> Rhinitis/Colds | <u>3</u> | <u>4</u> | <u>7</u> |
| <input type="checkbox"/> Nasal Polyps | _____ | _____ | _____ |
| <input checked="" type="checkbox"/> Sinusitis | _____ | <u>3</u> | <u>3</u> |
| <input type="checkbox"/> Tonsillopharyngitis | _____ | _____ | _____ |
| <input type="checkbox"/> Laryngitis | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |
| Respiratory: | | | |
| <input type="checkbox"/> Bronchitis | _____ | _____ | _____ |
| <input checked="" type="checkbox"/> Bronchial Asthma | <u>1</u> | <u>1</u> | _____ |
| <input checked="" type="checkbox"/> Pneumonia | <u>1</u> | <u>1</u> | <u>2</u> |
| <input type="checkbox"/> Tuberculosis | _____ | _____ | _____ |
| <input type="checkbox"/> Pneumoconiosis | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |
| Heart and Blood Vessel: | | | |
| <input checked="" type="checkbox"/> Hypertension | <u>4</u> | <u>2</u> | <u>6</u> |
| <input type="checkbox"/> Hypotension | _____ | _____ | _____ |
| <input checked="" type="checkbox"/> Angina Pectoris | _____ | <u>1</u> | <u>1</u> |
| <input type="checkbox"/> Myocardial Infarction | _____ | _____ | _____ |
| <input type="checkbox"/> Vascular disturbances In extremities due to Continuous vibration | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |
| Gastrointestinal: | | | |
| <input type="checkbox"/> Gastroenteritis/ Diarrhea | _____ | _____ | _____ |
| <input checked="" type="checkbox"/> Amoebiasis | _____ | <u>1</u> | <u>1</u> |
| <input checked="" type="checkbox"/> Gastritis/Hyperacidity | <u>4</u> | <u>6</u> | <u>10</u> |
| <input type="checkbox"/> Appendicitis | _____ | _____ | _____ |
| <input type="checkbox"/> Infectious Hepatitis | _____ | _____ | _____ |
| <input type="checkbox"/> Liver Cirrhosis | _____ | _____ | _____ |
| <input type="checkbox"/> Hepatic Abscess | _____ | _____ | _____ |
| <input type="checkbox"/> Cancer (Hepatic/Gastric) | _____ | _____ | _____ |
| <input type="checkbox"/> Ulcer | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |
| Genito Urinary: | | | |
| <input checked="" type="checkbox"/> Urinary Tract Infection | _____ | <u>2</u> | <u>2</u> |
| <input type="checkbox"/> Stones | _____ | _____ | _____ |
| <input type="checkbox"/> Cancers | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |
| Reproductive: | | | |
| <input checked="" type="checkbox"/> Dysmenorrhea | _____ | <u>5</u> | <u>5</u> |
| <input type="checkbox"/> Infection (Cervicitis) (Vaginitis) | _____ | _____ | _____ |
| <input type="checkbox"/> Abortion (Spontaneous) (Threatened) | _____ | _____ | _____ |
| <input type="checkbox"/> Hyperemesis Gravidarum | _____ | _____ | _____ |
| <input type="checkbox"/> Urine Tumors | _____ | _____ | _____ |
| <input type="checkbox"/> Cervical Polyp/Cancer | _____ | _____ | _____ |
| <input type="checkbox"/> Ovarian Cyst/Tumors | _____ | _____ | _____ |
| <input type="checkbox"/> Sexually-Transmitted Diseases | _____ | _____ | _____ |
| <input type="checkbox"/> Hernia (Inguinal) (Femoral) | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |
| Neuromuscular/Skeletal/Joints: | | | |
| <input type="checkbox"/> Peripheral Neuritis | _____ | _____ | _____ |
| <input type="checkbox"/> Torticollis | _____ | _____ | _____ |
| <input checked="" type="checkbox"/> Arthritis | <u>1</u> | _____ | <u>1</u> |
| <input checked="" type="checkbox"/> Others-Musculo-skeletal disturbances | _____ | <u>1</u> | <u>1</u> |

| | Male | Female | Total Number of Cases |
|---------------------------------------------------------------|-----------|-----------|--------------------------|
| Lymphatics and Circulatory: | | | |
| () Anemia | _____ | _____ | _____ |
| () Leukemia | _____ | _____ | _____ |
| () Cerebrovascular Accidents | _____ | _____ | _____ |
| () Lymphadenitis | _____ | _____ | _____ |
| () Lymphoma | _____ | _____ | _____ |
| Infectious Diseases: | | | |
| (X) Influenza | <u>1</u> | <u>1</u> | <u>2</u> |
| () Typhoid/Paratyphoid Fever | _____ | _____ | _____ |
| () Cholera | _____ | _____ | _____ |
| () Measles | _____ | _____ | _____ |
| () Tetanus | _____ | _____ | _____ |
| () Malaria | _____ | _____ | _____ |
| () Schistosomiasis | _____ | _____ | _____ |
| () Herpes Zoster | _____ | _____ | _____ |
| () Chicken Pox | _____ | _____ | _____ |
| () German Measles | _____ | _____ | _____ |
| () Rabies | _____ | _____ | _____ |
| (X) Others - Covid-19 | <u>2</u> | <u>2</u> | <u>4</u> |
| Diseases Due to Physical Environment: | | | |
| a) Disease 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 | _____ | _____ | _____ |
| () heat exhaustion | _____ | _____ | _____ |
| () Others | _____ | _____ | _____ |
| Cold Temperature | | | |
| () chilblain | _____ | _____ | _____ |
| () frost bite | _____ | _____ | _____ |
| () immersion foot | _____ | _____ | _____ |
| () general hypothermia | _____ | _____ | _____ |
| () Others | _____ | _____ | _____ |
| c) Diseases Due to Pressure Adnormalities: | | | |
| () Decompression Sickness: | | | |
| () Air embolism | _____ | _____ | _____ |
| () bends diseases | _____ | _____ | _____ |
| () Barotrauma | _____ | _____ | _____ |
| () Hypoxia | _____ | _____ | _____ |
| () altitude sickness | _____ | _____ | _____ |
| d) Diseases Due to Radiation | | | |
| () Cataracts | _____ | _____ | _____ |
| () keratitis | _____ | _____ | _____ |
| () burns | _____ | _____ | _____ |
| () radiation-related cancers | _____ | _____ | _____ |
| TOTAL NUMBER | <u>30</u> | <u>44</u> | <u>74</u> |

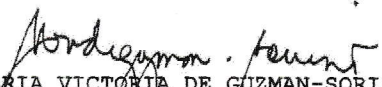
- () mist/fumes/vapors _____
 (Ex. Mist from paint _____
 Spraying) _____
- () gas (Ex. Co, H2S) _____
- () others (Please specify) _____
 (Ex. Solvents) _____
- b. Physical Hazards
- () Noise _____
- () temperature/humidity _____
 Pressure _____
- () illumination _____
- () radiation/ultraviolet/ _____
 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
 Medical Personnel/Title

January 25, 2022
 Date

Noted by:


MARIA VICTORIA DE GUZMAN-SORIANO
 VICE PRESIDENT FOR HR & ADMINISTRATION
 Employer