ADMISSIONS FORM 3
MEDICAL CERTIFICATE

(To be filled-out by the Nominee)

1. NAME ***(Last name, First Name, Middle Name)***			
2. DATE OF BIRTH (***mm/dd/yyyy***)	**3.** CIVIL STATUS	**4.** SEX ☐ Female ☐ Male	
5. WEIGHT (***kg***):	**6.** HEIGHT (***cm***):		
7. BP:	**8.** CR:		

9. Please check "Yes" or "No" if you had any of the following during the last 5 years :	**YES**	**NO**
a. Tuberculosis, asthma, emphysema, or other lung illnesses		
b. High blood pressure, heart by-pass, heart attack or other heart diseases		
c. Stomach ulcer, liver (hepatitis), gall bladder disease		
d. Kidney problem, stone or blood in urine		
e. Diabetes, sugar or glucose in blood or urine		
f. Depression, attempted suicide, or other psychological symptoms		
g. Tumor, abnormal growth, cyst or cancer		
h. Bleeding disorder, blood disease (sickle cell anemia)		
i. Malaria, Cholera, small pox or epidemic disease		
j. Allergy		
k. Other serious illnesses (Please specify)_____		

I certify that the above information is true and correct to the best of my knowledge. I understand that neither PMDP nor the implementing organization shall be liable for any physical or mental problem that I may develop during my participation in the program and that I shall be responsible for bringing with me necessary medicines as prescribed by my physician since they may not be available at the venue of the project.

_____ Date

_____ Nominee's Signature

*To be filled-out by the Physician from a **Government Hospital.***
Please attach laboratory results

GENERAL STATUS	
EENT:	**Ear**
Vision:	**Nose**
Snellens	**Throat**
RT. _____ **LT.** _____	**Neck**

Heart and Lungs

Chest: _____

X-Ray Findings: _____

Breast: _____

Abdomen: _____

History of Past Illness: _____

Hospitalization: _____

_____

_____

Remarks: _____

_____

_____

CERTIFICATION			
Based on above given information, I have examined the above nominee and certify that he/she is free from any ailment likely to impair the health of others and fit to participate in the PMDP referred to in this form.			
Hospital/Clinic's Name :			
Examiner's Name & License No. :			
Examiner's Signature :		Date:	