DOLE/BWC/OHSD/OH-47 A

Republic of the Philippines
Department of Labor and Employment
Bureau of Working Conditions

Occupational Health and Safety Division

ANNUAL MEDICAL REPORT FORM

For Period January 1, 19____ to December 31, 19_______

1. Name of Establishment: ____________________
2. Address: ____________________
3. Name of Owner/Manager: ____________________
4. Nature of Business and Products/Service (Ex. Manufacturing, Textile)
____
5. Total Number of Employees: __________ Number of Shifts: ____________________
6. Number Distribution of Employees as to nature of workplace, sex and workshift

	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 8a 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 nurse
Name: ____________________
Address: ____________________

d. The occupational health physician/practitioner/nurse/personnel conducts an inspection of the workplace:
( ) 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 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 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 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 Exams	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 cases diagnosed/treated for the following diseases ((/ of X):

	Male	Female	Total Number of Cases
Skin:			
( ) allergy	________	________	________
( ) dermatoses			
( ) infection as folliculitis/ absecess/paronychia	________	________	________
( ) Others	________	________	________
Head:			
( ) migraine headache	________	________	________
( ) 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	________	________	________
( ) Tonsillopharyngitis	________	________	________
( ) Laryngitis	________	________	________
( ) Others	________	________	________

	Male	Female	Total Number of Cases
Respiratory:			
( ) Bronchitis			
( ) Pronchial Asthma			
( ) Pneumonia			
( ) Tuberculosis			
( ) Pneumoconiosos			
( ) Others			
Heart and Blood Vessel:			
( ) Hypertension			
( ) Hypotension			
( ) Angina Pectoris			
( ) Myocardial Infarction			
( ) Vascular disturbances in extremeties due to continuous vibration			
( ) Others			
Gastrointestinal:			
( ) Gastroenteritis/Diarrhea			
( ) Amoebiasis			
( ) Gastritis/Hyperacidity			
( ) Appendicitis			
( ) Infectious Hepatitis			
( ) Liver Cirrhosis			
( ) Hepatic Absecess			
( ) Cancer (Hepatic/Gastric)			
( ) 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			
( ) Hernia (Inguinal)			
(Femoral)			
( ) Others			
Neuromuscular/Skeletal/Joints:			
( ) Peripheral Neuritis			
( ) Torticollis			
( ) Arthritis			
( ) Others			
Lymphatics and Circulatory:			
( ) Anemia			
( ) Leukemia			
( ) Cerebrovascular Accidents			
( ) Lymphadenitis			
( ) Lymphoma			
Infectious Diseases:			
( ) Influenza			
( ) Typhoid/Paratyphoid Fever			
( ) Cholera			
( ) Measles			

	Male	Female	Total Number of Cases
( ) Mumps	___________	___________	___________
( ) Tetanus	___________	___________	___________
( ) Malaria	___________	___________	___________
( ) Schistosomiasis	___________	___________	___________
( ) Herpes Zoster	___________	___________	___________
( ) Chicken Fox	___________	___________	___________
( ) German Measles	___________	___________	___________
( ) Rabies	___________	___________	___________
( ) Others	___________	___________	___________
Diseases due to Physical Environment:			
( ) Diseases due to abnormalities in temperature and humidity	___________	___________	___________
( ) Diseases due to abnormalities in air pressure	___________	___________	___________
( ) Poisoning/Overdosage to Chemicals	___________	___________	___________
TOTAL NUMBER	___________	___________	___________

11. Report of Occupational Accidents/Injuries

Nature	Male	Female	Parts of Body Affected Total Number of Cases
Contussion, bruises, hematoma	___________	___________	___________
Abrasions	___________	___________	___________
Cuts, Lacerations, punctures	___________	___________	___________
Concussion	___________	___________	___________
Avulsion	___________	___________	___________
Amputation, loss of body parts	___________	___________	___________
Crushing injuries	___________	___________	___________
Spinal injuries	___________	___________	___________
Cranial injuries	___________	___________	___________
Sprains	___________	___________	___________
Dislocation/Fractures	___________	___________	___________
Chemical Burns	___________	___________	___________

12. Immunization Program (Indicate the number)

Tetanus Taxoid Injection	___________	___________	___________
Tetanus Antitoxin Injection	___________	___________	___________
Tetanus Globulin Injection	___________	___________	___________
Anti-Cholera, Anti-Typhoid Triple Vaccine	___________	___________	___________
Others (Please specify)	___________	___________	___________

13. Keeping of Medical-Records of Workers (Please check) ( ) done ( ) not done

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

	Seminar	Use of Visual Aid/ Materials	Counselling
Nutrition Program			
Maternal and Childcare Program			
Family Planning Program			
Mental Health Activities			
Personal Health Maintenance			

Physical Fitness Program: (Please check)

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

16. Hazards in the Workplace: (Please check and give details of the active substance)

	Substances and/or Sources	Number of Workers Exposed
a. Chemicals Hazards:		
( ) dust (Ex. Silica dust)	____________________	____________________
( ) liquids (Ex. Mercury)	____________________	____________________
( ) mist/fumes/vapors (Ex. Mist from paint spraying)	____________________	____________________
( ) gas (Ex. CO, H_2S)	____________________	____________________
( ) others (please specify)	____________________	____________________
b. Physical Hazards:		
( ) noise	____________________	____________________
( ) temperature/humidity	____________________	____________________
( ) pressure	____________________	____________________
( ) illumination	____________________	____________________
( ) radiation/ultraviolet/microwave	____________________	____________________
( ) others (please specify)	____________________	____________________
c. Biological Hazards:		
( ) Viral	____________________	____________________
( ) Bacterial	____________________	____________________
( ) Fungal	____________________	____________________
( ) Parasitic	____________________	____________________
( ) Others	____________________	____________________
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