CSC FORM NO. 211 (1997)
MEDICAL CERTIFICATE
For Employment

PHILIPPINE CIVIL SERVICE

INSTRUCTIONS

1. This medical certificate should be accomplished by a government physician.
2. Attach this certificate to original appointments and reinstatements.

FOR THE PROPOSED APPOINTEE

NAME (*Last, First, Middle or if married woman, Maiden Name*)			AGENCY
ADDRESS			
AGE	SEX	CIVIL STATUS	PROPOSED POSITION

Pre-Employment Medical - Physical Tests

1. Blood Test
2. Urinalysis
3. Chest X-Ray
4. Drug Test
5. Neuro Psychiatric Examinations (if necessary)

NOTE: ALL RESULTS OF EXAMINATIONS MUST BE ATTACHED TO THIS FORM.

FOR THE PHYSICIAN

I hereby certify that I personally examined the above-named individual and found him/her to be physically and medically fit/unfit for employment.		AFFIX Documentary Stamp
PRINTED NAME/SIGNATURE OF PHYSICIAN	CERTIFICATE NUMBER	OTHER INFORMATION ABOUT THE PROPOSED APPOINTEE
OFFICIAL DESIGNATION		HEIGHT (Bare Feet) WEIGHT (Stripped) BLOOD TYPE
AGENCY		DATE EXAMINED

:-) puerick@mailcity.com.ph

Republic of the Philippines
Department of Education
HEALTH AND NUTRITION CENTER
Pasig City

ORAL HEALTH EXAMINATION RECORD FOR TEACHING AND NON-TEACHING PERSONNEL

Name: _____ Age: _____ Gender: _____
Date of Birth: _____ Marital Status _____
Region: _____ Division: _____ District: _____ School: _____
Designation: _____

Medical History:

☐ Hypertension ☐ Epilepsy ☐ Allergies
☐ Diabetes ☐ Bleeding Disorder ☐ Others:
☐ Cardio Vascular Dis. ☐ Asthma _____ Please Specify

DENTITION STATUS

INDEX : DMFT

Status																
	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
Status																

No. of T/Decayed	X –
	F –
No. of T/Missing	
No. of T/Filled	
Total	

TREATMENT RECORD

DATE	TOOTH NO.	NATURE OF OPERATION	REMARKS	DENTIST

Periodontal Condition:
☐ Normal
☐ Gingivitis
☐ Periodontal Disease

Other Abnormal Conditions
_____
Please Specify

DENTAL PROSTHESES
Denture wearer: ☐ Y ☐ N
Please Specify: _____
Need for Denture: ☐ Y ☐ N
Please Specify: _____

Remarks: _____
Remarks: _____
Remarks: _____

SYMBOLS FOR MOUTH EXAMINATION

X - Carious tooth indicated for extraction
F - Carious tooth indicated for filling
RF - Root fragment
O - Missing tooth
▽2 - Permanently filled tooth with recurrence of decay
Heavy Shade - Permanent filling
Outline of filling - tooth w/ temporary filling

Artificial Restoration:

JC - Jacket Crown
AB - Abutment
P - Pontic
I - Inlay
RPD - Removable Partial Deature
FB - Fixed Bridge
CD - Complete Denture

SYMBOLS FOR ACCOMPLISHMENT

OP - Oral Prophylaxis
Xt - Extracted permanent tooth
Ag F - Amalgam Filling
Sy P - Synthetic porcelain
GIC - Glass Ionomer Cement
ZnO F - Zinc Oxide Filling
R - Referred to private dentist

TREATMENT RECORD

DATE	TOOTH NO.	NATURE OF OPERATION	REMARKS	DENTIST

TEACHER'S HEALTH CARD

Date: _____
Name: _____ Date of Birth: _____ Age: _____ Gender: M F
School/District/Division: _____ Civil Status: S M W S
Position/Designation: _____ Years in Service: _____
First Year in Service: _____

Family History: *(pls. check)*	Y	N	Specify Relationship
Hypertension	[ ]	[ ]	_____
Cardiovascular Disease	[ ]	[ ]	_____
Diabetes Mellitus	[ ]	[ ]	_____
Kidney Disease	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Asthma	[ ]	[ ]	_____
Allergy	[ ]	[ ]	_____

Other Remarks: _____
_____

Past Medical History: (check)

	Y	N		Y	N
Hypertension	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Asthma	[ ]	[ ]	Surgical Operations (pls. specify)	[ ]	[ ]
Diabetes Mellitus	[ ]	[ ]	Yellowish discoloration of skin/sclera	[ ]	[ ]
Cardio Vascular Disease	[ ]	[ ]	Last hospitalization (reason)	[ ]	[ ]
Allergy (pls. specify) _____			Others (pls. specify) _____		

Last Taken	Date	Result		Date	Result	
CXR/Sputum Result:	_____	_____	Drug Testing:	_____	_____	Others: specify _____
ECG	_____	_____	Neuropsychiatric exam:	_____	_____	
Urinalysis	_____	_____	Blood Typing:	_____	_____	

Social History

Smoking Y _____ N _____ Age started: _____ Sticks/packs per day: _____ Pack per year: _____
Alcohol Y _____ N _____ How often: _____ Food preference: _____

OB Gyn History *(pls. encircle)* (Female Teachers)

Menarche _____ Cycle_____ Duration _____
Parity: F P A L
Papsmear done: Y N if YES, when: _____
Self Breast examination done: Y N
Mass noted: Y N Specify where:
For Male personnel: Digital rectal examination done: Y N Date examined: _____
Result: _____

Present Health Status *(pls. check)*	Y	N		Y	N
Cough 2wks 1month longer			Lumps	[ ]	[ ]
Dizziness	[ ]	[ ]	Painful urination	[ ]	[ ]
Dyspnea	[ ]	[ ]	Poor/loss of hearing	[ ]	[ ]
Chest/Back pain	[ ]	[ ]	Syncope/fainting	[ ]	[ ]
Easy fatigability	[ ]	[ ]	Convulsions	[ ]	[ ]
Joint/extremity pains	[ ]	[ ]	Malaria	[ ]	[ ]
Blurring of vision	[ ]	[ ]	Goiter	[ ]	[ ]
Wearing eyeglasses	[ ]	[ ]	Anemia	[ ]	[ ]
Vaginal discharge/bleeding	[ ]	[ ]	Others: *(pls. specify)* _____		

Dental Status: *(pls. specify)* _____
Present medications taken: *(pls. specify)* _____

Legend:				
	CXR	-Chest X-ray	PTB	-Pulmonary Tuberculosis
	ECG	-Electro-Cardio Gram	F	-Full Term
	Y	-Yes	P	-Pre-mature
	N	-No	A	-Abortion
	HPN	-Hypertension	L	-Live Birth
	CVD	-Cardio Vascular Disease		
	DM	-Diabetes Mellitus		

Interviewed by: _____
Date:

CS Form 86

HEALTH EXAMINATION RECORD

Name: _____ Division: _____ Department: _____

Date of Birth: _____ Type of Work: _____ Sex: _____ Civil Status: _____

1	Date:	Date:	Date:
	Height	Height	Height
	Weight	Weight	Weight
2	Temperature:		
3	Respiratory System:		
	Fluorography:		
	Sputum Analysis:		
4	Circulatory System:		
	Blood Pressure:		
	Pulse:		
	Sitting: Agility Test:	Sitting: Agility Test:	Sitting: Agility Test:
5	Digestive System:		
6	Genito-Urinary:		
	Urinalysis, etc.:		
7	Skin:		
8	Locomotor System:		
9	Nervous System:		
10	Eyes: Conjunctivitis, etc.:		
	Color Perception:		
11	Vision:		
	With glasses: Far: _____ Near: _____	With glasses: Far: _____ Near: _____	With glasses: Far: _____ Near: _____
	Without glasses: Far: _____ Near: _____	Without glasses: Far: _____ Near: _____	Without glasses: Far: _____ Near: _____
12	Nose:		
13	Ear:		
14	Hearing:		
	Right: Left:	Right: Left:	Right: Left:
15	Throat:		
16	Teeth and Gums:		
17	Immunization:		
18	Remarks:		
19	Recommendation:		
20	Employee's Signature:		
	Employee's Name (Print):		
21	Physician's Signature:		
	Physician's Name (Print):		

Republic of the Philippines
DEPARTMENT OF EDUCATION
Region X
DIVISION OF MISAMIS ORIENTAL
Cagayan de Oro City
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/ e-mail: decsmisor@norminet.org.ph

Neuro - Psychiatric Examination Consent Form

I, _____ , a Teacher I - applicant of _____
(*Name*) (*School*)
_____, of legal age, _____, Filipino and presently residing at
(*Civil Status*)
_____ do hereby freely, knowingly,
(*Permanent Address*)
voluntarily, and intelligently give my consent to abide with the Guidelines in the conduct of the Neuro-Psychiatric Examination as enumerated hereunder.

GUIDELINES IN NEURO-PSYCHIATRIC EXAMINATION

To ensure that mentally fit teachers and non-teaching personnel are hired, this division requires Neuro-Psychiatric Examination to be done prior to appointment be it for substitute or permanent position.

The following steps should be followed:

1. The applicant should attend the orientation prior to laboratory examinations.
2. He / she should inform the school nurse of his/her schedule when to submit for Neuro-psychiatric examination.
3. The applicant is free to choose a Medical Doctor, specifically a **Psychiatrist** to conduct a Neuropsychiatric Examination.
4. The School Nurse should accompany the applicant during the entire duration of the examination.
5. In the test result, a 2x2 ID picture is attached. The applicant affixed his/her signature in the presence of the examining doctor.
6. Test result should be given to the school nurse in a sealed envelop to be delivered to the Division Medical Officer.
7. The Division Medical Officer opens the sealed envelop and have the teacher affixed his /her thumb mark in the test result.
8. The applicant should sign a consent agreeing to the Neuro-psychiatric procedure required by the division.
9. Neuropsychiatric Examination is valid for six (6) months (unless necessary).

_____
(Signature)

Subscribed and Sworn to before me this _____day of_____at Cagayan de Oro City, Philippines.

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Series of