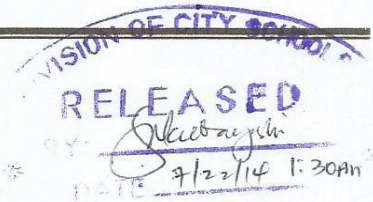


Republic of the Philippines
Department of Education
National Capital Region
DIVISION OF CITY SCHOOLS
City of Mandaluyong

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July 22, 2014




**MEDICAL CERTIFICATE REQUIREMENT IN THE
APPLICATION FOR THE DIVISION SUBSIDIZED SCHOLARSHIP GRANT
TO TEACHING AND NON-TEACHING PERSONNEL
FOR SCHOOL YEAR 2014-2015**

MEMORANDUM TO: Assistant Schools Division Superintendent
Education and District Supervisors
Principals, Public Elementary and Secondary Schools
Administrative Officer V
Division Section Chiefs
President, Mandaluyong Federation of Public School Teachers Association, Inc. (MFPSTA)
President, Mandaluyong Association of Non-Teaching Personnel (MANTEP)
Nationally Paid Non-Teaching Personnel

This is to inform the field that the medical certificate requirement in the application for the Division Subsidized Scholarship Grant to Teaching and Non-Teaching Personnel for School Year 2014-2015 can be the CSC Form No. 86 or the CSC Form No. 211 (copy attached). There is no need to attach the medical examination results of the applicant. The above-stated form/s of medical certificate is enough.

Prompt and wide dissemination of this **Memorandum** is desired.


EVANGELINE P. LADINES, CESO VI
Schools Division Superintendent

HEALTH EXAMINATION RECORD

Name : _____ Bureau : _____ Department : _____
Date of Birth : _____ Sex : _____ Civil Status : _____ Type of Work : _____

- 1. Date : _____ Age : _____ Height : _____ cm. Weight _____ kg.
- 2. Temperature : _____
- 3. Respiratory System : _____
- 4. Fluorescopy : _____
- 5. Sputum Analysis : _____
- 6. Circulatory System : _____
- 7. Blood Pressure : Systolic : _____ Diastolic : _____
- 8. Pulse Sitting : _____ Agility Test : _____ after 3 minutes
- 9. Blood Analysis : _____
- 10. Digestive System : _____
- 11. Genito-urinary : _____
- 12. Skin : _____
- 13. Locomotor System : _____
- 14. Nervous System : _____
- 15. Eyes : Conjunctive, etc. : _____
- 16. Color Perception : _____
- 17. Vision : Without Glasses Far R _____ L _____ Near R _____ L _____
With Glasses Far R _____ L _____ Near R _____ L _____
- 18. Ears : _____
- 19. Hearing : Right Ear : _____ Left Ear : _____
- 20. Nose : _____
- 21. Throat : _____
- 22. Teeth & Gums : _____
- 23. Immunization : _____ Date : _____
- 24. Remarks : _____
- 25. Recommendation : _____
- 26. Employee's Signature : _____
- 27. Physician's Signature : _____
Address : _____

Note: All entries must be written in ink. Any erasure or correction must be signed over by the physician.

INSTRUCTIONS

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

FOR THE PROPOSED APPOINTEE

NAME (<i>Last, First, Middle, or if married women, Maiden Name</i>)			AGENCY/ADDRESS
ADDRESS			PROPOSED POSITION
AGE	SEX	CIVIL STATUS	

Pre-Employment Medical - Physical Tests

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

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

FOR THE PHYSICIAN

<i>I hereby certify that I have personally examined the above named individual and found her/him to be physically and medically fit/unfit for employment.</i>			<div style="border: 2px solid black; padding: 5px; display: inline-block;"> AFFIX Documentary Stamp here </div>		
PRINTED NAME/SIGNATURE OF PHYSICIAN	CERTIFICATE NUMBER	OTHER INFORMATION ABOUT THE PROPOSED APPOINTEE			
OFFICIAL DESIGNATION		HEIGHT <i>(Bare feet)</i>	WEIGHT <i>(Stripped)</i>	BLOOD Type	
AGENCY		DATE EXAMINED			