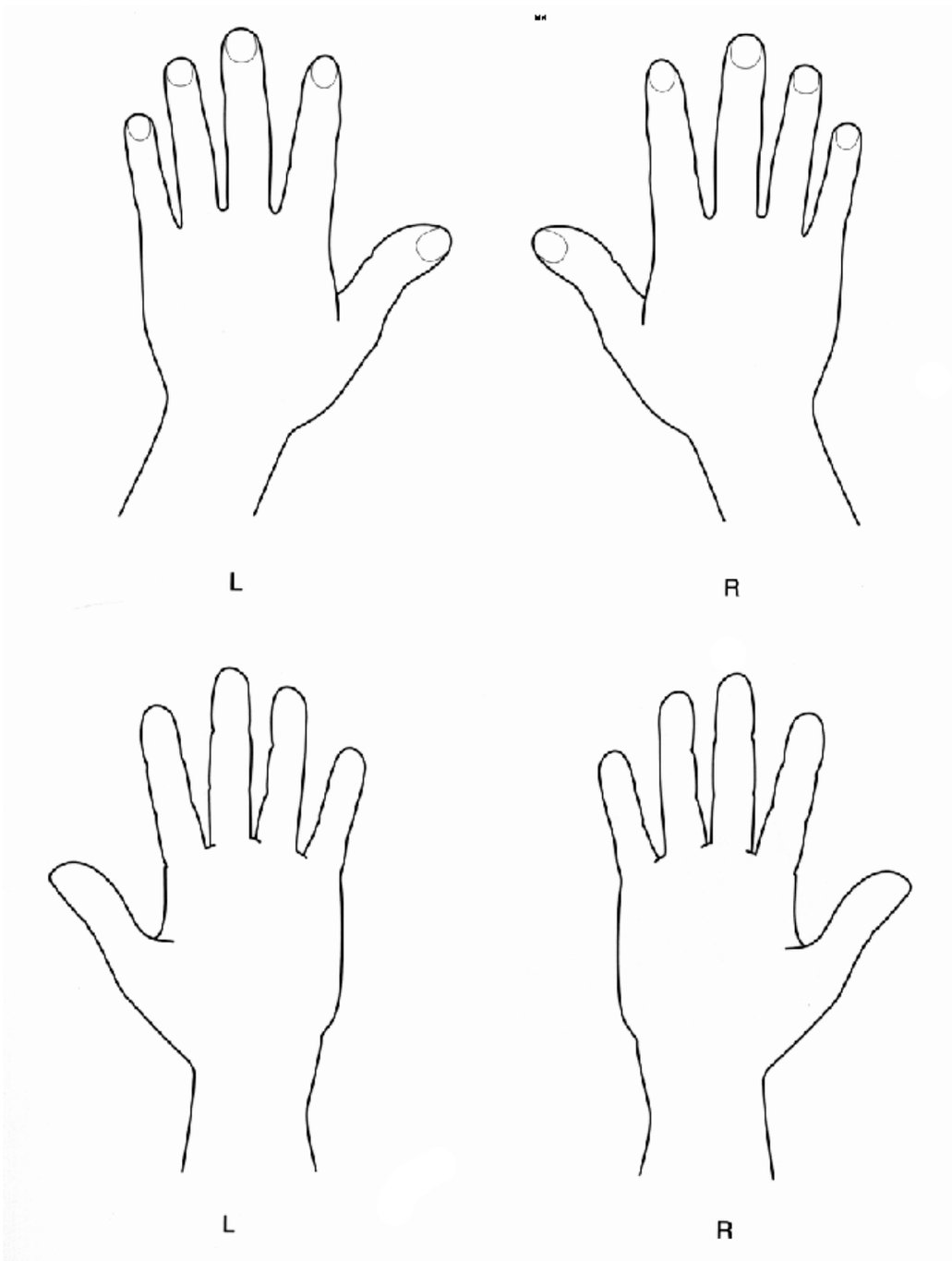
Republic of the Philippines
City Government of Antipolo
ANTIPOLO CITY HOSPITAL SYSTEM - ANNEX

Control No. _____
ML No. _____
Date: _____

Last name: _____ First Name: _____ Middle Name: _____

Sex: [] Male. [] Female Age: _____

Date of examination: _____ _____ A.M. _____ P.M.



_____
Name and Signature of Examining physician