



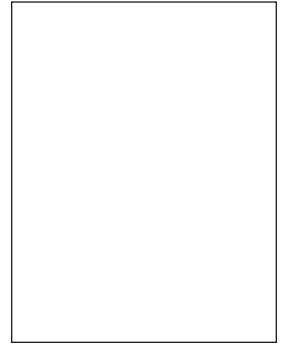
# MEGA MANPOWER CORPORATION

## MEDICAL SERVICES DIVISION

**Quality** not *Quantity*.

POEA License No. 061 - LB - 030316 - R  
Rooms 501 & 502 Gedisco Terrace,  
1148 Roxas Blvd. Ermita, Manila  
Like us on facebook: /megamanpower

**t** : 5226657 / 5222836 / 5252442  
**f** : +63 (2) 404-3322  
**e** : info@megamanpower.com  
**w** : www.megamanpower.com



### INTERVIEW RATING SHEET

POSITION APPLIED

#### PERSONAL INFORMATION

NAME				CONTROL NO.	
	LAST	FIRST	MIDDLE	RELIGION	
HIGHEST EDUCATION				DATE OF BIRTH	
NO. OF YEARS OF EXPERIENCE	LOCAL		ABROAD	AGE	

#### MEDICAL EQUIPMENT HANDLED


#### INTERVIEWER'S COMMENTS

INTERVIEWER'S RATING

INTERVIEWED BY

DATE



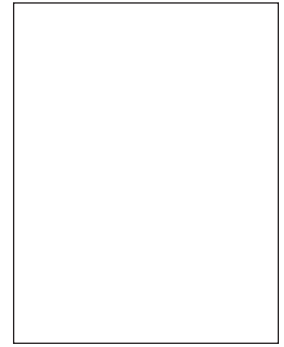
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POSITION (1st Choice) ▶	
POSITION (2nd Choice) ▶	
POSITION (3rd Choice) ▶	

PERSONAL INFORMATION						
NAME ▶	Last ▲		First ▲		Middle ▲	Date Applied ▶
						Religion ▶
Highest Education ▶					Date of Birth ▶	
No. of Years of Experience ▶	Local ▶			Abroad ▶		
					Age ▶	
Complete City Address ▶					Landline No. ▶	
Complete Provincial Address ▶					Cellphone No. ▶	
E-mail Address ▶					Skype ID ▶	
Civil Status ▶	Gender ▶	<input type="checkbox"/> Male <input type="checkbox"/> Female		Weight ▶	Height ▶	
Name of Spouse ▶			No. of Children ▶			Date of Birth ▶
Name of Father ▶					Date of Birth ▶	
Name of Mother ▶					Date of Birth ▶	

EDUCATIONAL ATTAINMENT		
NAME OF SCHOOL	YEAR From ▼ - To ▼	DEGREE / COURSE ▼
High School ▶		
Vocational ▶		
College/University ▶		
Masteral ▶		

WORK EXPERIENCE (Present to Previous)			
Company Name ▶			
Company Address ▶	Agency ▶		
Position ▶	From ▶	mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶			Salary ▶
Brief Job Description ▶			

Company Name ▶			
Company Address ▶	Agency ▶		
Position ▶	From ▶	mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶			Salary ▶
Brief Job Description ▶			

**WORK EXPERIENCE (Present to Previous)**

Company Name ▶												
Company Address ▶					Agency ▶							
Position ▶					From ▶	mo.	day	year	To ▶	mo.	day	year
Reason for Leaving ▶								Salary ▶				
Brief Job Description ▶												

Company Name ▶												
Company Address ▶					Agency ▶							
Position ▶					From ▶	mo.	day	year	To ▶	mo.	day	year
Reason for Leaving ▶								Salary ▶				
Brief Job Description ▶												

Company Name ▶												
Company Address ▶					Agency ▶							
Position ▶					From ▶	mo.	day	year	To ▶	mo.	day	year
Reason for Leaving ▶								Salary ▶				
Brief Job Description ▶												

Company Name ▶												
Company Address ▶					Agency ▶							
Position ▶					From ▶	mo.	day	year	To ▶	mo.	day	year
Reason for Leaving ▶								Salary ▶				
Brief Job Description ▶												

Company Name ▶												
Company Address ▶					Agency ▶							
Position ▶					From ▶	mo.	day	year	To ▶	mo.	day	year
Reason for Leaving ▶								Salary ▶				
Brief Job Description ▶												

Company Name ▶												
Company Address ▶					Agency ▶							
Position ▶					From ▶	mo.	day	year	To ▶	mo.	day	year
Reason for Leaving ▶								Salary ▶				
Brief Job Description ▶												

**TRAININGS AND SEMINARS**

Title ▶															
Venue ▶															
Date Started ▶					No. of Hours ▶				Date End ▶				Date Expiry ▶		

Title ▶															
Venue ▶															
Date Started ▶					No. of Hours ▶				Date End ▶				Date Expiry ▶		

OTHER INFORMATION			
Special Skills	▶		
Special Equipment and Test Instrument you can Operate	▶		
Computer Application / Software you can Operate	▶		
Organization Affiliations	▶		
PRC License Number	▶	Passport Number	▶
PRC Profession	▶	Passport Date of Issuance	▶
PRC Rating	▶	Passport Expiry Date	▶
PRC Date Issuance	▶	Saudi Council License Number	▶
PRC Expiry Date	▶	Saudi Council License Expiry Date	▶
NBI Clearance Expiry Date	▶	SSS/GSIS Number	▶
Pag-ibig Number	▶	Drivers License No.	▶
Philhealth Number	▶	Drivers License Expiry Date	▶

NAME OF PERSON TO CONTACT IN CASE OF URGENT MESSAGE			
Name	▶	Date of Birth	▶
Relationship	▶	Landline No.	▶
		Cellphone No.	▶
Address	▶	Email Address	▶

HOW DID YOU LEARN ABOUT THE VACANCY?	
Biography - Tell something about yourself	▶

I, \_\_\_\_\_, hereby state that I am applying to work in \_\_\_\_\_ as \_\_\_\_\_ and that the information given above are true and correct to the best of my knowledge. I also commit myself to abide by and comply with all the provisions of the placement contract that I will execute with **MEGA MANPOWER CORPORATION** and the Employment Contract that I will execute and sign with my foreign Employer until its completion. I also authorize **MEGA MANPOWER CORPORATION** and my foreign Employer to bring the case to the proper Court and authorizes in the job site and in the National Capital Region of the Philippines should I fail to fulfill and comply with all provisions of my placement and **Employment Contract**.

\_\_\_\_\_  
Signature of Applicant ▲

Name of Candidate : \_\_\_\_\_ Control No.: \_\_\_\_\_

Position Applied : \_\_\_\_\_ Contact No.: \_\_\_\_\_

**VERIFICATION OF EMPLOYMENT HISTORY**

Name of Employer		Contact Number	
Date of Employment		Email Address	
Address		Contact Person	

Result of Verification (To be fill up by Mega Staff):

Name of Employer		Contact Number	
Date of Employment		Email Address	
Address		Contact Person	

Result of Verification (To be fill up by Mega Staff):

Name of Employer		Contact Number	
Date of Employment		Email Address	
Address		Contact Person	

Result of Verification (To be fill up by Mega Staff):

Verified by: \_\_\_\_\_

**SWORN STATEMENT  
ON SUBMISSION OF FALSE INFORMATION  
AND FALSIFIED DOCUMENTS  
AND COMPLIANCE WITH FINANCIAL OBLIGATIONS  
AS EX-OVERSEAS WORKER**

I, \_\_\_\_\_, of legal age, Filipino, [civil status] and with residence at \_\_\_\_\_, after having been duly sworn according to law, hereby state that:

1 I have applied with MEGA MANPOWER, INC. ("Agency", for brevity) for employment overseas as a \_\_\_\_\_;

2 That I have submitted my application/bio-data and other supporting documents to the Agency and have been required by it to submit other documents to the Agency;

3 That I have previously worked overseas, the specific details of which are contained in my application/bio-data;

4 That I hereby attest and confirm that all of the information in my application/bio-data are complete, true and correct and that all of the documents I have submitted and will submit to the Agency are totally genuine and authentic;

5 That I hereby acknowledge that I have been advised and warned by the Agency that, if I make any false statement in my application/bio-data and other documents which I have submitted and will submit in support of my application and/or if I use or submit any falsified, fake, fabricated or spurious document in connection with my application, I can be charged with and found guilty of falsification and other crimes under Article 171, 172, 175 and 178 of the Revised Penal Code;

6 That I hereby further acknowledge that I have also been advised and warned by the Agency that using, providing or submitting false information or documents for purposes of job application or employment is a SERIOUS OFFENSE under the 2016 POEA Rules and Regulations, for which I can be suspended or disqualified from participation in the overseas employment program, i.e., I cannot be hired, processed and deployed as an OFW by any recruitment agency, including the POEA;

7 That I hereby consent, agree and undertake that, if I commit any such crime or offense or if I commit any act of falsification or faking of documents like birth certificate, passport, professional license, school records, TESDA/training/employment/medical certificates and other documents or if I commit any fraud, deceit or misrepresentation in support of my application for employment or in connection with my selection, processing and deployment and also during my employment, the following may occur:

- a. Rejection or denial of my application for overseas employment;
- b. Cancellation or withdrawal of my job offer;
- c. Cancellation of my employment contract;
- d. Cancellation of my Overseas Employment Certificate;
- e. Withdrawal or denial of my application for entry visa/work permit;
- f. Cancellation of my visa/work permit;
- g. Cancellation of my plane ticket and flight booking;
- h. Cancellation of my deployment;
- i. Dismissal from my job;
- j. Arrest and detention by the host government;
- k. Imposition of imprisonment and fine;
- l. Repatriation to the Philippines at my expense without recourse;
- m. Reimbursement of costs and expenses shouldered by the Agency and my employer for my processing, deployment and repatriation costs, including damages; and
- n. Report to the Department of Foreign Affairs and other government agencies.

7. That I shall hold the Agency free and clear from any liability and I shall assume sole and exclusive responsibility for my submission of false information or falsified documents;

8. That, having previously worked overseas, I hereby declare that I have no existing residual financial obligations or loans to any company, bank, financing institution, credit card company, lending company or any individual, foreign or Filipino, in the countries where I used to be employed and that I have not been charged with and/or found guilty of renegeing/defaulting on such obligations or loans;

9. That, if it turns out that I have such unpaid financial obligations or loans, I shall assume sole/exclusive responsibility for the repayment or settlement thereof and interests, surcharges and penalties, including criminal penalties, if applicable, in addition to the sanctions stated in paragraph 7 hereinabove;

10. That I know how to read English and I have read the foregoing and I fully understand and voluntarily agree to the content hereof.

IN WITNESS WHEREOF, I have signed this Statement this \_\_\_\_ day of \_\_\_\_\_, 20\_\_ at \_\_\_\_\_, Philippines.

\_\_\_\_\_  
Signature over Printed Name  
Affiant

SUBSCRIBED AND SWORN to before me, a Notary Public for and in \_\_\_\_\_, Philippines, by \_\_\_\_\_, who personally appeared before me on this \_\_ day of \_\_\_\_\_, 20\_\_ and who provided competent evidence of his/her identity in the form of his/her \_\_\_\_\_ No. \_\_\_\_\_ valid until \_\_\_\_\_.

Doc. No. \_\_\_\_\_;  
Page No. \_\_\_\_\_;  
Book No. \_\_\_\_\_;  
Series of \_\_\_\_\_

# MEDICAL QUESTIONNAIRE

**Instructions to Applicants:**

Please complete this form together with the application form and checklist.

**Applicants Name**

(Last, First, Middle Name): \_\_\_\_\_

**Age:** \_\_\_\_\_

**Position Applied:** \_\_\_\_\_ **Date:** \_\_\_\_\_

SCORE

**Section A:** Have you ever have any of the following? for "Yes" answers, supply full details on right side of page or Section B.

**GENERAL:**

- |   |                              |                             |       |
|---|------------------------------|-----------------------------|-------|
| 1. Exercise in tolerance                                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 2. Fatigability   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 3. Weight change (plus/minus 10 lbs)                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| <input type="checkbox"/> Gain <input type="checkbox"/> Loss |                              |                             |       |
| 4. Change in Appetite                                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |

**SECTION B**

**INTEGUMENTARY (SKIN):**

- |  |                              |                             |       |
|--|------------------------------|-----------------------------|-------|
| 5. Rashes/ Urticaria                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 6. Ulcers/ Sores/ Scabies/ Psoriasis/ Eczema | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |

**EYES:**

- |  |                              |                             |       |
|--|------------------------------|-----------------------------|-------|
| 7. Do you wear glasses/contact lenses?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 8. History of blurring of vision   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 9. Do you have a history of cataracts?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 10. Glaucoma   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 11. Blindness  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Both |                              |                             |       |

**EAR, NOSE, MOUTH AND THROAT:**

- |  |                              |                             |       |
|--|------------------------------|-----------------------------|-------|
| 12. Do you have any hearing loss?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> Both |                              |                             |       |
| 13. Use of hearing aid   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 14. Chronic sinus problems/ Sinusitis  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| <input type="checkbox"/> Pain <input type="checkbox"/> Congestion                                  |                              |                             |       |
| 15. Do you have frequent nose bleeding?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 16. Hoarseness/ Changes in voice   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 17. Recurrent sore throat  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 18. Bleeding gums  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 19. Difficulty in swallowing   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 20. Oral thrust  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |

**RESPIRATORY:**

- |   |                              |                             |       |
|---|------------------------------|-----------------------------|-------|
| 21. Do you have wheezes/ crackles?                                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 22. On and off productive cough   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 23. Coughed with blood  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 24. Do you experience shortness of breath?                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| <input type="checkbox"/> At rest <input type="checkbox"/> With activity |                              |                             |       |
| 25. Pneumonitis   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 26. Asthma  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 27. Lung disease/ Lung scar   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |

**CARDIOVASCULAR:**

- |   |                              |                             |       |
|---|------------------------------|-----------------------------|-------|
| 28. Chest pain, pressure or tightness                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| <input type="checkbox"/> At rest <input type="checkbox"/> With activity |                              |                             |       |
| 29. Heart palpitations (on exertion)                                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |
| 30. Irregular heartbeats  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <hr/> |

\_\_\_\_\_  
Signature of Applicant

- 31. Swelling of feet or ankles  YES  NO \_\_\_\_\_
- 32. Pain in legs while walking  YES  NO \_\_\_\_\_
- 33. Hypertension/ Hypotension  YES  NO \_\_\_\_\_
- 34. Cardiac arrhythmias  YES  NO \_\_\_\_\_
- 35. On and off chest pain  YES  NO \_\_\_\_\_
- 36. Missed beats  YES  NO \_\_\_\_\_

**GASTROINTESTINAL SYSTEM:**

- 37. Abdominal pain/ Hernia  YES  NO \_\_\_\_\_
- 38. Black, tarry stool  YES  NO \_\_\_\_\_
- 39. Bright red blood in stool  YES  NO \_\_\_\_\_
- 40. History of stomach ulcers  YES  NO \_\_\_\_\_
- 41. Irregular bowel movements/ History of amebiasis  YES  NO \_\_\_\_\_
- 42. History of gallbladder problems  YES  NO \_\_\_\_\_
- 43. History of liver problems/ Hepatitis  YES  NO \_\_\_\_\_
- 44. Rectal bleeding  YES  NO \_\_\_\_\_

**GENITOURINARY:**

- 45. Do you have pain or burning sensation during urination?  YES  NO \_\_\_\_\_
- 46. History of bladder, kidney infection  YES  NO \_\_\_\_\_
- 47. History of kidney stones/ kidney disease  YES  NO \_\_\_\_\_
- 48. Males: Prostate problems  YES  NO \_\_\_\_\_
- 49. Females: Post menopausal/ ovarian cyst/ myoma  YES  NO \_\_\_\_\_
- 50. Currently taking hormone replacement  YES  NO \_\_\_\_\_

**MUSCULOSKELETAL:**

- 51. Chronic/ acute back pain  YES  NO \_\_\_\_\_
- 52. Arthritis  YES  NO \_\_\_\_\_
- 53. History of gout/ High uric acid  YES  NO \_\_\_\_\_
- 54. Joint pain or stiffness  YES  NO \_\_\_\_\_
- 55. Limited joint movement  YES  NO \_\_\_\_\_
- 56. Muscle pain or cramps  YES  NO \_\_\_\_\_
- 57. Muscle weakness  YES  NO \_\_\_\_\_
- 58. History of varicose veins  YES  NO \_\_\_\_\_
- 59. Carpal tunnel syndrome  YES  NO \_\_\_\_\_

**NEUROLOGICAL:**

- 60. Temporary weakness, numbness and/ or tingling involving an arm and leg?  YES  NO \_\_\_\_\_
- 61. Severe headaches/ on and off dizziness  YES  NO \_\_\_\_\_
- 62. Convulsions/ Seizures  YES  NO \_\_\_\_\_
- 63. Epilepsy  YES  NO \_\_\_\_\_
- 64. Tremors  YES  NO \_\_\_\_\_
- 65. Pain in spinal region  YES  NO \_\_\_\_\_

**ENDOCRINE:**

- 66. High cholesterol  YES  NO \_\_\_\_\_
- 67. Diabetes/ Juvenile Diabetes/ Gestational Diabetes  YES  NO \_\_\_\_\_
- 68. Thyroid problems/ (Hyperthyroidism/ Hypothyroidism)  YES  NO \_\_\_\_\_

**HEMATOLOGICAL/IMMUNOLOGIC:**

- 69. History of recurrent hematoma  YES  NO \_\_\_\_\_
- 70. Allergies (On and off - food, drug etc.)  YES  NO \_\_\_\_\_
- 71. History of anemia  YES  NO \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant



**PSYCHIATRIC HISTORY**

Are any of the following areas of your life particularly stressful to you? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Marriage/Relationship | <input type="checkbox"/> Health          |
| <input type="checkbox"/> Financial problems    | <input type="checkbox"/> Family problems |

**Please explain:**

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Have you ever been treated for a psychiatric illness (depression, anxiety, bipolar etc.?)

Have you ever been treated in psychiatric facility?

If you have been treated with the above illness please list down medications that you are currently taking?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

I further affirm that the information and responses I have provided are accurate and true to the best of my knowledge.

---

**Signature of Applicant**