



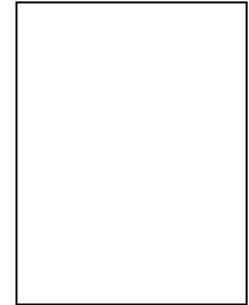
INDOSEHAT 2003
CLINIC & MEDICAL CHECK-UP



SURAT KETERANGAN **TO WHOM IT MAY CONCERN**

Dengan ini kami menerangkan bahwa :
Here with acknowledge that :

Nama
Name : MUH. AGUNG ADRISAH
Jenis Kelamin
Gender / Sex : PRIA / MALE
Tempat / Tanggal Lahir
Place / Date Of Birth : KASSIKA / 08 SEPTEMBER 2002
Perusahaan
Company : PRIVATE
Jabatan
Occupation : 3RD OFFICER



Benar telah melakukan Medical Check-Up di Indosehat 2003 Medical Centre.
Have trully complete Medical Standart Check-Up in Indosehat 2003 Medical Centre.

Dengan Hasil : Sehat untuk Bertugas.
With Final Result : FIT.

Demikian surat keterangan ini kami sampaikan untuk dapat dipergunakan sebagaimana mestinya.
I hope this letter will be found useful where necess.



MUH. AGUNG ADRISAH

Jakarta, 11 July 2025



[Signature]
dr. Widha Puji Ismayawati
Examination

Date Of Examination, July 11, 2025
Expiration Of Validity, July 11, 2027



MEDICAL EXAMINATION REPORT

COMPANY	: PRIVATE	
MCU NO.	: 0126/MCUIIS_PW/PVT/I/25	
NAME	: MUH. AGUNG ADRISAH	
SEX	: PRIA/MALE	DATE EXAMINE : 11/07/2025
PLACE & DATE OF BIRTH	: KASSIKA / 08 SEPTEMBER 2002	NATIONALITY : INDONESIA
MAILING ADDRESS OF EXAMINEE	: JL. RAJAWALI NO. 13 B, KEC. MARISO, KOTA MAKASSAR, SULAWESI SELATAN	
DUTY	: 3RD OFFICER	PASSPORT : X 6110843

MEDICAL HISTORY (EXAMINE PERSONAL DECLARATION)		PHYSICAL EXAMINATION					
	Yes / No	HEIGHT	WEIGHT	BMI	BLOOD PRESSURE	PULSE REGULAR	RESPIRATORY RATE
1. ALCOHOL HISTORY	No	160 cm	80 kg	31.30 kg/m ²	110/80 mmHg	83 X/min	19 X/min
2. ALLERGIC HISTORY	No						
3. AMPUTATION	No	VISION	WITHOUT	WITH	COLOR VISION (ISHIHARA'S METHOD)		
4. BLOOD DISORDER	No	Right Eye	6/7.5		NORMAL		
5. BALANCE PROBLEM	No	Left Eye	6/10				
6. BACK OR JOINT PROBLEM	No	Both Eye	6/10				
7. COLOUR BLINDNESS	No	GENERAL APPEARANCE					
8. CANCER	No	LOOKING HEALTHY					
9. DIABETES	No						
10. DIGESTIVE DISORDER	No						
11. DEPRESION	No	NORMAL					
12. EPILEPSY	No						
13. EYE / VISION PROBLEM	No	1. EYES				Yes	
14. EAR PROBLEM	No	2. EARS				Yes	
15. FRACTURE	No	3. NOSE				Yes	
16. GENITAL DISORDER	No	4. MOUTH				Yes	
17. HEART SURGERY	No	5. THROAT				Yes	
18. HEART DISEASE	No	6. NECK				Yes	
19. HIGH BLOOD PRESSURE	No	7. THROID				Yes	
20. HERNIA	No	8. LYMP NODE				Yes	
21. INFECTIOUS DISEASE	No	9. LUNGS				Yes	
22. KIDNEY PROBLEM	No	10. HEARTS				Yes	
23. LUNG DISEASE	No	11. ABDOMEN				Yes	
24. LIVER PROBLEM	No	12. UROGENITAL SYSTEM				Yes	
25. LOST OF MEMORY	No	13. UPPER EXTREMITIES				Yes	
26. NARCOTIC HISTORY	No	14. LOWER EXTREMITIES				Yes	
27. NEUROLOGICAL DISEASE	No	15. BACK ABNORMALITY				Yes	
28. OPERATION / SURGERY	No	16. HERNIA				Yes	
29. PSYCHIATRIC PROBLEM	No	17. CENTRAL NERVOUS SYSTEM				Yes	
30. RESTRICTED MOBILITY	No	18. SKIN & NAILS				Yes	
31. SKIN PROBLEM	No	19. SPEECH				Yes	
32. SLEEP PROBLEM	No	20. OTHERS				Yes	
33. THYROID PROBLEM	No						
34. TUBERCULOSIS	No						
35. SMOKING	No						
DENTAL EXAMINATION		HEARING		If abnormal, give details			
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8		NORMAL					
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8		Right Ear	Yes				
• : Filling O : Caries ^ : Root Rest		Left Ear	Yes				
x : Missing V : Prothesa							

