

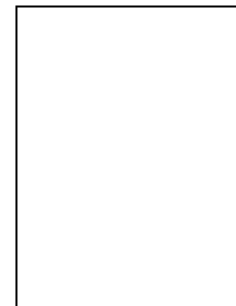
INDOSEHAT 2003
CLINIC & MEDICAL CHECK-UP



SURAT KETERANGAN **TO WHOM IT MAY CONCERN**

Dengan ini kami menerangkan bahwa :
Here with acknowledge that :

Nama
Name : YUSRIZAL ODE
Jenis Kelamin
Gender / Sex : PRIA / MALE
Tempat / Tanggal Lahir
Place / Date Of Birth : JIKOHAY / 08 MARCH 2000
Perusahaan
Company : PRIVATE
Jabatan
Occupation : AB



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.



YUSRIZAL ODE

Jakarta, 14 July 2025



dr. Widha Puji Ismayawati
Examination

Date Of Examination, July 14, 2025
Expiration Of Validity, July 14, 2027



MEDICAL EXAMINATION REPORT

COMPANY	: PRIVATE	
MCU NO.	: 0564/MCUIS_CW/PVT/1/25	
NAME	: YUSRIZAL ODE	
SEX	: PRIA/MALE	DATE EXAMINE : 14/07/2025
PLACE & DATE OF BIRTH	: JIKOHAY, 08 MARCH 2000	NATIONALITY : INDONESIA
MAILING ADDRESS OF EXAMINE	: DUSUN TAHOKU, DESA HILA KEC. LEIHITU KAB. MALUKU TENGAH	
DUTY	: AB	PASSPORT : X 4854616

MEDICAL HISTORY (EXAMINE PERSONAL DECLARATION)		PHYSICAL EXAMINATION					
	Yes / No	HEIGHT	WEIGHT	BMI	BLOOD PRESSURE	PULSE REGULAR	RESPIRATORY RATE
1. ALCOHOL HISTORY	No	168 cm	58 kg	20.5 kg/m ²	120/80 mmHg	80 X/min	20 X/min
2. ALLERGIC HISTORY	No						
3. AMPUTATION	No						
4. BLOOD DISORDER	No	VISION	WITHOUT	WITH	COLOR VISION (ISIHARA'S METHOD)		
5. BALANCE PROBLEM	No	Right Eye	6/6		NORMAL		
6. BACK OR JOINT PROBLEM	No	Left Eye	6/7,5				
7. COLOUR BLINDNESS	No	Both Eye	6/6				
8. CANCER	No	GENERAL APPEARANCE					
9. DIABETES	No	LOOKING HEALTHY					
10. DIGESTIVE DISORDER	No	NORMAL 1. EYES Yes 2. EARS Yes 3. NOSE Yes 4. MOUTH Yes 5. THROAT Yes 6. NECK Yes 7. THROID Yes 8. LYMP NODE Yes 9. LUNGS Yes 10. HEARTS Yes 11. ABDOMEN Yes 12. UROGENITAL SYSTEM Yes 13. UPPER EXTREMITIES Yes 14. LOWER EXTREMITIES Yes 15. BACK ABNORMALITY Yes 16. HERNIA Yes 17. CENTRAL NERVOUS SYSTEM Yes 18. SKIN & NAILS Yes 19. SPEECH Yes 20. OTHERS Yes					
11. DEPRESION	No						
12. EPILEPSY	No						
13. EYE / VISION PROBLEM	No						
14. EAR PROBLEM	No						
15. FRACTURE	No						
16. GENITAL DISORDER	No						
17. HEART SURGERY	No						
18. HEART DISEASE	No						
19. HIGH BLOOD PRESSURE	No						
20. HERNIA	No						
21. INFECTIOUS DISEASE	No						
22. KIDNEY PROBLEM	No						
23. LUNG DISEASE	No						
24. LIVER PROBLEM	No						
25. LOST OF MEMORY	No						
26. NARCOTIC HISTORY	No						
27. NEUROLOGICAL DISEASE	No						
28. OPERATION / SURGERY	No						
29. PSYCHIATRIC PROBLEM	No						
30. RESTRICTED MOBILITY	No						
31. SKIN PROBLEM	No						
32. SLEEP PROBLEM	No						
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 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 • : Filling O : Caries ^ : Root Rest x : Missing V : Prothesa		Right Ear NORMAL Yes Left Ear Yes					

