



INDOSEHAT 2003
CLINIC & MEDICAL CHECK-UP



SURAT KETERANGAN **TO WHOM IT MAY CONCERN**

Dengan ini kami menerangkan bahwa :
Here with acknowledge that :

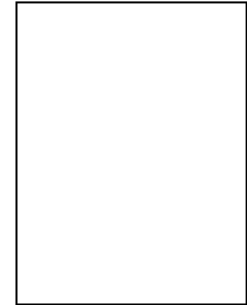
Nama
Name : HARYANTO PARINDING

Jenis Kelamin
Gender / Sex : PRIA / MALE

Tempat / Tanggal Lahir
Place / Date Of Birth : UJUNG PANDANG / 01 AUGUST 1992

Perusahaan
Company : PRIVATE

Jabatan
Occupation : CHIEF ENGINEER



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.



HARYANTO PARINDING

Jakarta, 07 August 2025



dr. Widha Puji Ismayawati
Examination

Date Of Examination, August 07, 2025
Expiration Of Validity, August 07, 2027



MEDICAL EXAMINATION REPORT

COMPANY	: PRIVATE	
MCU NO.	: 1748/MCUIS_CW/PVT/I/25	
NAME	: HARYANTO PARINDING	
SEX	: PRIA/MALE	DATE EXAMINE : 07/08/2025
PLACE & DATE OF BIRTH	: UJUNG PANDANG, 07 AUGUST 1992	NATIONALITY : INDONESIA
MAILING ADDRESS OF EXAMINE	: JL. BIRING ROMANG BLOK 1 NO. 45/35 PERUMNAS ANTANG, MAKASSAR, SULAWESI SELATAN	
DUTY	: CHIEF ENGINEER	PASSPORT : E 2661334

MEDICAL HISTORY (EXAMINE PERSONAL DECLARATION)		PHYSICAL EXAMINATION											
	Yes / No	HEIGHT	WEIGHT	BMI	BLOOD PRESSURE	PULSE REGULAR	RESPIRATORY RATE						
1. ALCOHOL HISTORY	No	170 cm	82 kg	28.4 kg/m ²	120/80 mmHg	80 X/min	20 X/min						
2. ALLERGIC HISTORY	No												
3. AMPUTATION	No	VISION	WITHOUT	WITH	COLOR VISION (ISIHARA'S METHOD)								
4. BLOOD DISORDER	No	Right Eye	6/7,5		NORMAL								
5. BALANCE PROBLEM	No	Left Eye	6/7,5										
6. BACK OR JOINT PROBLEM	No	Both Eye	6/6										
7. COLOUR BLINDNESS	No	GENERAL APPEARANCE											
8. CANCER	No	LOOKING HEALTHY											
9. DIABETES	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 											
10. DIGESTIVE DISORDER	No												
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								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 x : Missing V : Prothesa								Left Ear	Yes				

