



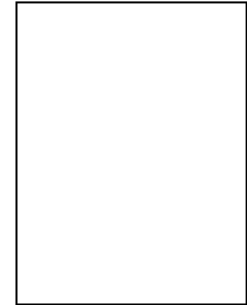
INDOSEHAT 2003
CLINIC & MEDICAL CHECK-UP



SURAT KETERANGAN **TO WHOM IT MAY CONCERN**

Dengan ini kami menerangkan bahwa :
Here with acknowledge that :

Nama
Name : LINGGA YOPRANOTO PAULUS
Jenis Kelamin
Gender / Sex : PRIA / MALE
Tempat / Tanggal Lahir
Place / Date Of Birth : POLMAS / 06 DECEMBER 1990
Perusahaan
Company : PRIVATE
Jabatan
Occupation : 2ND 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.



LINGGA YOPRANOTO PAULUS

Jakarta, 10 July 2025



dr. Widha Puji Ismayawati
Examination

Date Of Examination, July 10, 2025
Expiration Of Validity, July 10, 2027



MEDICAL EXAMINATION REPORT

COMPANY	: PRIVATE	
MCU NO.	: 3697/MCUIS_CW/PVT/1/25	
NAME	: LINGGA YOPRANOTO PAULUS	
SEX	: PRIA/MALE	DATE EXAMINE : 10/07/2025
PLACE & DATE OF BIRTH	: POLMAS / 06 DECEMBER 1990	NATIONALITY : INDONESIA
MAILING ADDRESS OF EXAMINE	: SALLY, RT 007/ RW 002, DESA. SALLY , KEC. MIOMAFFO BARAT, KAB. TIMOR TENGAH UTARA, PROVINSI NUSA TENGGARA TIMUR	
DUTY	: 2ND ENGINEER	PASSPORT : X 4244050

MEDICAL HISTORY (EXAMINE PERSONAL DECLARATION)		PHYSICAL EXAMINATION											
	Yes / No	HEIGHT	WEIGHT	BMI	BLOOD PRESSURE	PULSE REGULAR	RESPIRATORY RATE						
1. ALCOHOL HISTORY	No	167 cm	85 kg	30.50 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. EYESYes 2. EARSYes 3. NOSEYes 4. MOUTHYes 5. THROATYes 6. NECKYes 7. THROIDYes 8. LYMP NODEYes 9. LUNGSYes 10. HEARTSYes 11. ABDOMENYes 12. UROGENITAL SYSTEMYes 13. UPPER EXTREMITIESYes 14. LOWER EXTREMITIESYes 15. BACK ABNORMALITYYes 16. HERNIAYes 17. CENTRAL NERVOUS SYSTEMYes 18. SKIN & NAILSYes 19. SPEECHYes 20. OTHERSYes 											
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 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								NORMAL					
								Right Ear	Yes				
								Left Ear	Yes				