

## HEALTH CHECK CONSENT

### A. Why do you need to do this health assessment? read and sign this Consent to a Health Check form?

In accordance with Ambatovy's Medical Fitness for Work Policy and Standards, all expatriates involved with any work, on any Ambatovy site for longer than 4 weeks' duration (cumulative during a 12-month period) must undergo a standardised pre-employment / annual health assessment.

Ambatovy (the Company), has requested that you undergo a Health Check. This will include:

- Medical examination;
- Medical investigations and tests as required by the Company, based on local laws or health risks; and
- Travel Medical Requirements.

### B. Who should conduct the health assessment?

Please attend to a reputable clinic with qualified medical personnel that can perform all required investigations. Ambatovy does not take any responsibility for the level of care or quality of services rendered by the service that you choose. Additional medical examinations or tests may be requested as needed.

### C. You Agree that:

- The Provider you choose is responsible for their own medical practice, chain of custody procedures, diagnostic processes, accuracy and interpretation of results and you hold the International SOS Group and your current or future employer harmless for the actions or inactions of the Providers.
- The medical service provider and the Company are not responsible for diagnosing or treating any medical condition revealed by the health assessment.
- You have read and clearly understood all information provided in this document.
- Any decisions made by the Company based on the health assessment about your employment or fitness to travel to site or remain on site are not the responsibility of the Company.
- This form is valid as soon as it is signed, even if it is a copy, photocopy, electronic or fax.
- You will provide truthful information to the Provider rendering the service of the health assessment.

### D. Consent to the health assessment

By signing this form, you confirm that you have read and understood the above explanation.

Consent given on (date):

August 07th 2023

By (Print Name):

Paulo Miguel Machado Caldeira

Signature:

*Paulo Miguel Machado Caldeira*

Name of Child / Legal Dependant:

Name of Parent or Legal Guardian:

Consent given on (date):

Signature:

*Paulo Miguel Machado Caldeira*

## HEALTH ASSESSMENT

### **Note to Applicant:**

Please read through the following information closely.

Complete the **Health Assessment Consent, Privacy Notice Consent and Section A and B** before your medical examination. The examining Physician can assist you with the completion of section B. Please contact the CMO (isos.cmo@ambatovy.mg) if you require any further information.

Keep original records on your files

### **Note to attending Physician:**

Please note that this medical screening assessment is for assignment purposes only. Any treatment or further investigation resulting from conditions discovered through the screening will need to be done by separate private appointment and consultation, at the patient's own cost.

**Complete separate forms for each of:**

**the work applicant (Sections A to J)**

### **Site medical information and requirements:**

Ambatovy has medical facilities on both the Plant and Mine sites. This includes a well-equipped emergency room, a short stay critical care ward, a short stay non-emergency ward, X-ray facilities (Mon-Fri) and laboratory facilities (Mon-Fri). International SOS manages the facilities and provides the medical care.

Services include:

- Primary Health Care and short stay ward admissions for non-emergency cases
- Emergency Care and stabilisation is provided by the Emergency Physician and Chief Medical Officer.
- Life threatening cases are stabilized on site and referred by medical evacuation flight to the appropriate specialist care in Johannesburg, South Africa

Please take note of the following:

- Certain medications are not available in Madagascar – bring enough chronic medication for the duration of your stay. Remember to bring a prescription from your doctor should airport officials request it.
- Visit your local travel clinic and update all your vaccinations
- Certain medical services, blood tests and specialist consultations are not available in Madagascar.
- Attend to routine medical care (i.e. GP check-up, Dermatology, annual cancer screening, Dental, Gynaecology etc.) in home country before departure or when on rotational leave
- Madagascar is an endemic Malaria area. Bring your malaria prophylaxis with you. Doxycycline and atovaquone/proguanil (Malarone) is available for purchase in local pharmacies

### **Vaccination information:**

- For mobilisation to site the following vaccines are **required**:
  - Full Covid-19 vaccination (proof required)
- For travel to Madagascar the following vaccines are highly recommended:
  - Typhoid
  - Diphtheria
  - Tetanus
  - Hepatitis A
  - Hepatitis B

### **Minimum health and safety standards to be met:**

- Age must be less than 65 years
- Total body weight must be less than 120kg

- All medical conditions must be controlled on appropriate medication (proof of control, and sign off by managing physician may be required)
- Multiple factors play a role in deciding a person's fitness for work status, and each case is assessed individually as per the Ambatovy Fitness For Work Policy, Standard Operating Procedure and Procedures.

## A. PERSONAL INFORMATION

<b>Title</b>	<input checked="" type="checkbox"/> <b>Mr</b>	<input type="checkbox"/> <b>Ms</b>	<input type="checkbox"/> <b>Mrs</b>	<input type="checkbox"/> <b>Doctor</b>	<input type="checkbox"/> <b>Other</b>
<b>Family Name</b> (Last Name)	Caldeira				
<b>Given Name</b> (First Name)	Paulo				
<b>Gender and status</b>	<input checked="" type="checkbox"/> <b>Male</b>	<input type="checkbox"/> <b>Female</b>	<input type="checkbox"/> <b>Employee</b>	<input type="checkbox"/> <b>Spouse</b>	<input type="checkbox"/> <b>Child</b>
<b>Date of Birth</b>	Age: 45      Date of Birth: 18th April 1978				
<b>Nationality</b>	Portuguese				
<b>Passport Number</b>	CD556435				
<b>Marital Status</b>	<input type="checkbox"/> <b>Single</b>	<input checked="" type="checkbox"/> <b>Married</b>	<input type="checkbox"/> <b>Divorced</b>	<input type="checkbox"/> <b>Widowed</b>	<input type="checkbox"/> <b>Other</b>
<b>Home Address</b>	Rua Dr Joao de Brito Camacho				
	21-A, 1Dto, 7700-041 Almodovar				
	City Almodovar			Country Portugal	
<b>Work Phone</b>	+1 (829) 977-4397		<b>Mobile Phone</b>	+351926509677	
<b>Home Phone</b>	+351286665675		<b>Fax Number</b>		
<b>Email</b>	pmmcaldeira@gmail.com				
<b>Emergency contact</b>	Eliane Caldeira		<b>Relationship</b>	Spouse	
<b>Contact Number</b>	+351927396180		<b>Alternative Number</b>	+351286665675	
<b>Home Address</b>	Rua Dr Joao de Brito Camacho				
	21-A, 1Dto, 7700-041 Almodovar				
	City Almodovar			Country Portugal	
<b>Position Applied For</b>	Senior Project Engineer				

B. MEDICAL HEALTH HISTORY

<b>FAMILY HISTORY</b> (First degree relatives - parents, siblings, or children)				
<input type="checkbox"/> Heart operations		<input type="checkbox"/> High cholesterol		
<input type="checkbox"/> Congenital heart disease		<input type="checkbox"/> Diabetes		
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Any other major illness		
Details of problems and in addition, please identify at what age the condition occurred.				
<b>LIFESTYLE</b>				
<input type="checkbox"/> Do you drink alcohol?   YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<input type="checkbox"/> How many units per week on average?				
<input type="checkbox"/> Do you smoke cigarettes?   YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<input type="checkbox"/> How many per day on average?				
<input type="checkbox"/> Do you exercise frequently?   YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<input type="checkbox"/> Type and frequency of exercise: Walking daily, swimming weekly				
<b>OCCUPATIONAL HISTORY</b>				
Position	Company	Type of Industry	From year	To year
Senior Project Engineer	Barrick Gold - Pueblo Viejo Dominicana Corporation	Mining	2022	2023
Engineer (Técnico Superior)	Lundin Mining SOMINCOR Sociedade Mineira de Neves-Corvo	Mining	2010	2022
Quality Engineer	EMEF (Comboios de Portugal)	Railway	2009	2010
Engineer (Técnico Superior)	Lundin Mining SOMINCOR Sociedade Mineira de Neves-Corvo	Mining	2008	2009

## OCCUPATIONAL EXPOSURES

- |  |  |  |
|--|--|--|
| <input checked="" type="checkbox"/> Excessive Noise              | <input checked="" type="checkbox"/> Mercury            | <input type="checkbox"/> Radioactivity       |
| <input checked="" type="checkbox"/> Toxic Chemicals              | <input checked="" type="checkbox"/> Other heavy metals | <input type="checkbox"/> Other not mentioned |
| <input checked="" type="checkbox"/> Dust / Silica Dust/ Asbestos | <input checked="" type="checkbox"/> Heat               |  |

### Details:

Working inside Mineral Processing Concentrators (Cu, Zn, Pb and Au) treating VMS types of ore, and in ancillary facilities including Ore Park and Concentrate load-out, Electrical Substations, Pipe-Racks and Tailings ponds.

Have you ever received any compensation related to work-related injury? YES ☐ NO ☒

### Details:

## OCCUPATIONAL HAZARDS

Will you be required to perform emergency response team duties? YES ☐ NO ☒

Will you be required to wear a respirator? YES ☐ NO ☒

Will you be working at heights? YES ☐ NO ☒

Will you be working in confined spaces? YES ☐ NO ☒

## VACCINATIONS

Covid -19 vaccinated?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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Please send proof of ALL vaccines that you have received including all Covid-19 vaccinations.

## BLOOD GROUP

Blood group ☒ O+ ☐ O- ☐ A+ ☐ A- ☐ B+ ☐ B- ☐ AB+ ☐ AB

Do you have any objection to receive a blood transfusion in the event of an emergency? ☐ YES ☒ NO

## PAST MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
<b>NEUROLOGICAL</b>			<b>GASTROINTESTINAL</b>			<b>Ankle abnormalities</b>		×
<b>Epilepsy/Seizures</b>		×	<b>Gallstones</b>		×	<b>Leg length discrepancies</b>		×
<b>Stroke</b>		×	<b>Chron's disease</b>		×	<b>Able to wear safety boot</b>	×	
<b>Migraines</b>		×	<b>Ulcerative colitis</b>		×	<b>CARDIAC CONDITIONS</b>		
<b>Myasthenia Gravis</b>		×	<b>Pancreatitis</b>		×	<b>Heart attack</b>		×
<b>Parkinson's Disease</b>		×	<b>Vomiting blood</b>		×	<b>Angioplasty</b>		×
<b>Multiple Sclerosis</b>		×	<b>Unexplained weight loss</b>		×	<b>Stent</b>		×
<b>Manganese toxicity</b>		×	<b>Chronic diarrhoea</b>		×	<b>Atrial fibrillation</b>		×
<b>EAR,NOSE, THROAT</b>			<b>Rectal bleeding</b>		×	<b>Atrial flutter</b>		×
<b>Hearing loss</b>		×	<b>Hepatitis B</b>		×	<b>Implantable cardiac device</b>		×
<b>Acoustic neuroma</b>		×	<b>Hepatitis C</b>		×	<b>Pacemaker</b>		×
<b>Sinusitis</b>		×	<b>Peptic Ulcer</b>		×	<b>Coronary bypass surgery</b>		×
<b>Hay fever</b>		×	<b>Heartburn</b>		×	<b>High blood pressure</b>		×
<b>Balance problems</b>		×	<b>MUSCULOSKELETAL</b>			<b>Blood clots</b>		×
<b>Meniere's disease</b>		×	<b>White finger</b>		×	<b>Pulmonary embolism</b>		×
<b>VISION</b>			<b>Back pain</b>		×	<b>PULMONARY CONDITIONS</b>		
<b>Blindness</b>		×	<b>Back surgery</b>		×	<b>Asthma</b>		×
<b>Retinal detachments</b>		×	<b>Neck pain</b>		×	<b>Emphysema</b>		×
<b>Glaucoma</b>		×	<b>Neck surgery</b>		×	<b>Chronic bronchitis</b>		×
<b>Colour deficiency</b>		×	<b>Knee abnormalities</b>		×	<b>Silicosis</b>		×
<b>Contact lenses</b>		×	<b>Shoulder abnormalities</b>		×	<b>Asbestosis</b>		×
<b>Glasses</b>	×		<b>Hip abnormalities</b>		×	<b>Tuberculosis</b>		×

Details of problems indicated above:

Use of corrective glasses for distance vision.

Female: Last Normal Menstruation Date

## ALLERGIES

Do you suffer from any allergies to medication, food or substances?

☐ Yes

☒ No

Do you suffer from any allergic medical conditions?

☐ Yes

☒ No

### Details

Minor seasonal allergies in Spring

## ILLNESS RECORD

Any periods of extended work absence due to sickness in past 2 years?

☐ Yes

☒ No

### Details

Never had to be absent from work for medical reasons

## HOSPITAL ADMISSIONS AND OPERATIONS

Year 2023

### Details

One minor surgery to remove one node in the chest near the shoulder without requiring general anesthesia or internment (ambulatory).

## CHRONIC MEDICAL CONDITIONS

Year of diagnosis

Diagnosis

## CHRONIC MEDICATION

Medication

Dosage

Script

## C. PHYSICAL EXAMINATION

Appearance			
Body weight	77.11 kg	Systolic Blood pressure	120 mmHg
Height	163.83cm	Diastolic Blood Pressure	80 mmHg
Body mass Index	28.73	Pulse Rate and Rhythm	90
Oral temperature	37°C	Respiratory Rate	20 /minute
Please indicate ABNORMALITY PRESENT with an (X) in box			
<input type="checkbox"/> Jaundice <input type="checkbox"/> Anaemia <input type="checkbox"/> Cyanosis <input type="checkbox"/> Clubbing <input type="checkbox"/> Peripheral edema <input type="checkbox"/> General Lymphadenopathy <input type="checkbox"/> Skin and subcutaneous tissue <input type="checkbox"/> Pupils <input type="checkbox"/> Fundoscopy <input type="checkbox"/> Otoscopy <input type="checkbox"/> Nasal Mucosa and Septum <input type="checkbox"/> Sinuses <input type="checkbox"/> Mouth and gums <input type="checkbox"/> Teeth <input type="checkbox"/> Oropharynx	<input type="checkbox"/> Thyroid <input type="checkbox"/> Trachea <input type="checkbox"/> Heart sounds <input type="checkbox"/> Pedal pulses <input type="checkbox"/> Varicosities <input type="checkbox"/> Respiratory fields <input type="checkbox"/> Abdominal masses <input type="checkbox"/> Abdominal tenderness <input type="checkbox"/> Liver and Spleen <input type="checkbox"/> Ascites <input type="checkbox"/> Hernia orifices <input type="checkbox"/> Anal hemorrhoids or fissures <input type="checkbox"/> Scrotal contents <input type="checkbox"/> Penile lesions or discharge <input type="checkbox"/> Musculoskeletal deformities	<input type="checkbox"/> Gait and station <input type="checkbox"/> Joints and range of motion <input type="checkbox"/> Muscle strength and tone <input type="checkbox"/> Cranial nerves <input type="checkbox"/> Tendon reflexes <input type="checkbox"/> Sensation  <b>In Patient health interest the following examinations are recommended annually.</b>  <b>Indicate (✓) if done:</b> <input type="checkbox"/> Prostate (Male over 50 year) <input type="checkbox"/> Breasts (All Females) <input type="checkbox"/> Mammogram (Female > 40 year) <input type="checkbox"/> Pelvic exam / Ultrasound (All Females) <input type="checkbox"/> PAP Smear (All females)	
Details of any physical abnormalities found			
<p>Repeat blood pressure after 5 minutes, if initial reading is <math>\geq 140/90</math> mmHg</p>			



## D. ECG

**A 12-lead ECG is required. Computerised interpretation alone is not sufficient. Medical examiner interpretation is required. Please provide copy of ECG to patient/send with report**

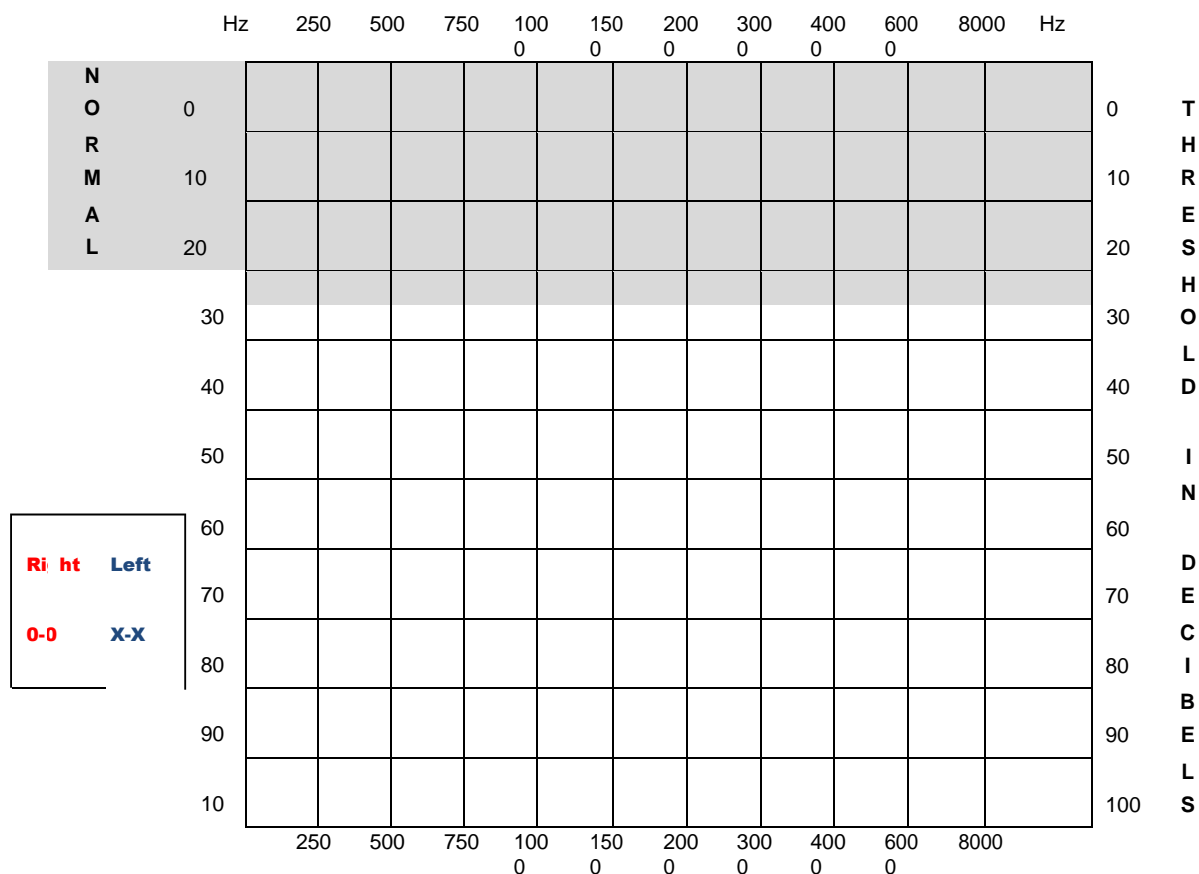
<b>Resting ECG (All candidates &gt; 50 years of age)</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Comments and recommendations</b> <b>SINUS ARRHYTHMIA, EVALUATE IN ONE YEAR</b>		

## E. AUDIOMETRY TEST

**(Performed 16 hours after any noise exposure > 80dB, in a booth with ambient noise level < 40dB)**

### Audio/Hearing Questionnaire

Have you ever worked in noisy environments? Y ☒ N ☐  
 Do any of your family members have hearing problems? Y ☐ N ☒  
 Do you have irritating noises in your head or ears(tinnitus)? Y ☐ N ☒  
 Do you have problems such as excessive wax, ear infections or blockages? Y ☐ N ☒  
 Do you partake in noisy activities such as motorbike/car/racing, shooting etc? Y ☐ N ☒  
 Do you wear hearing aids? Y ☐ N ☒  
 Have you ever had: Meningitis, Mumps, Measles, Scarlet, Fever, Rheumatic Fever or TB? (if 'yes' please specify) Y ☐ N ☒



**NORMAL AUDIOMETRY**

## F. VISION TEST

If yes to color vision deficiency, please specify to which colors: Red ☐ Green ☐ Yellow ☐ Blue ☐

<b>Visual Acuity with Correction – Near Vision</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Visual Acuity with Correction – Distant Vision</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Visual Fields</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Depth Perception</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Colour Blindness</b>	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Yes
<b>Fundoscopy</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Tonometry</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<b>Comments</b> CORRECTED AMETROPIA, MANDATORY AND PERMANENT USE OF IST CORRECTIVE LENSES AND ANNUAL EVALUATION OF IST VISUAL ACUITY.		

## G. RESPIRATORY FUNCTION TEST

```

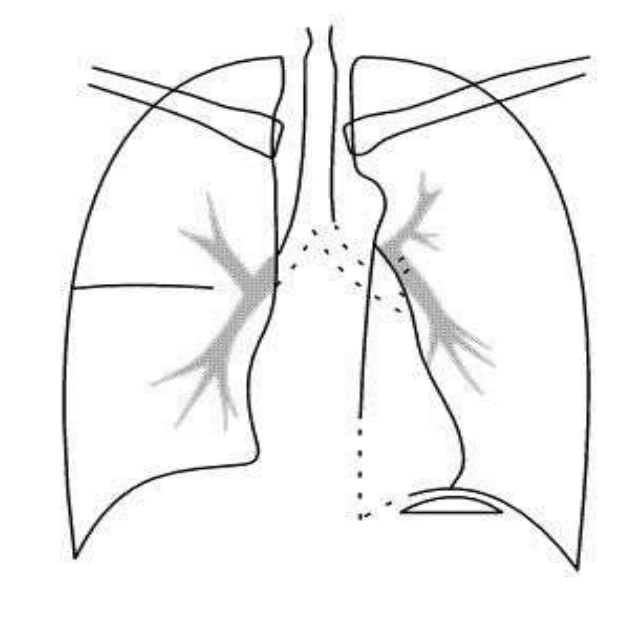
graph TD
    A[Predicted FVC] -- ">=80%" --> B[FEV1/ FVC(%) ]
    A -- "<80%" --> C[FEV1/ FVC(%) ]
    B -- ">=70%" --> D[Normal]
    B -- "<70%" --> E[Obstructive]
    C -- ">=70%" --> F[Mixed]
    C -- "<70%" --> G[Restrictive]
    D -.-> H[Severity]
    E -.-> I[FEV1/FVC]
    F -.-> J[FEV1]
    G -.-> K[FVC]
    H --> H1[Mild]
    H --> H2[Moderate]
    H --> H3[Severe]
    I --> I1[60-74%]
    I --> I2[41-59%]
    I --> I3[<40%]
    J --> J1[60-79%]
    J --> J2[41-59%]
    J --> J3[<40%]
    K --> K1[60-79%]
    K --> K2[51-59%]
    K --> K3[<50%]

```

Test	Measured	Predicted	Percentage
<b>FVC</b>			4.26L
<b>FEV1</b>			83.1%
<b>FEV1/FVC</b>			113.3%
<b>Type</b>	<input type="checkbox"/> Restrictive	<input type="checkbox"/> Obstructive	<input type="checkbox"/> Mixed
<b>Severity</b>	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<b>Comments</b> NORMAL PULMONARY FUNCTION, EVALUATE IN ONE YEAR.			

## H. CHEST X-RAY

Quality	
	Penetration (vertebrae is visible through heart)
	Rotation (clavicle heads' in relation to spine)
	Inspiration ( more than 9 ribs visible)
	Angulation (clavicles over 3rd rib)
Central zone	
	Trachea (in midline)
	Mediastinum (not widened)
	Hilum (no vascular prominence or enlargement)
	Heart (not more than half of thoracic width)
Middle zone	
	Parenchymal abnormalities (no opacities, cavities)
	Pleural abnormalities (no thickening)
	Costo-phrenic angle (no obliteration)
Outer zone	
	Soft tissues(normal neck, breasts, habitus)
X	Bones (normal vertebrae, ribs, clavicles, shoulders)



## I. LABORATORY TESTS

Diabetic Screen / Control					
Glucose Random	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Hb1Ac	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Glucose Fasting	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Amylase	<input type="radio"/> Normal	<input type="radio"/> Abnormal

Serology					
HIV	<input type="radio"/> Positive	<input checked="" type="radio"/> Negative	Hepatitis B	<input type="radio"/> Positive	<input checked="" type="radio"/> Negative
Syphilis	<input type="radio"/> Positive	<input checked="" type="radio"/> Negative	Hepatitis C	<input type="radio"/> Positive	<input checked="" type="radio"/> Negative

Urinalysis					
Blood	<input type="radio"/> Positive	<input type="radio"/> Negative	Protein	<input type="radio"/> Positive	<input checked="" type="radio"/> Negative
Glucose	<input type="radio"/> Positive	<input checked="" type="radio"/> Negative	Other	<input type="radio"/> Positive	<input type="radio"/> Negative

Drug Screen		
<input type="radio"/> Positive	<input checked="" type="radio"/> Negative	Details:

Full Blood Count					
WBC	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Haemoglobin	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal
Basophil	<input type="radio"/> Normal	<input type="radio"/> Abnormal	MCV	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal
Eosinophil	<input type="radio"/> Normal	<input type="radio"/> Abnormal	MCH	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal
Lymphocytes	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	MCHC	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal
Monocytes	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	RDW	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Neutrophils	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Platelets	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal
RBC	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	MPV	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal
Haematocrit	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	ESR	<input type="radio"/> Normal	<input type="radio"/> Abnormal

## I. LABORATORY TESTS (Continued)

Liver Function					
ALT	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Bilirubin - Direct	<input type="radio"/> Normal	<input type="radio"/> Abnormal
AST	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Bilirubin -Indirect	<input type="radio"/> Normal	<input type="radio"/> Abnormal
ALP	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Bilirubin Total	<input type="radio"/> Normal	<input type="radio"/> Abnormal
YGT	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Albumin	<input type="radio"/> Normal	<input type="radio"/> Abnormal
LDH	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Total Protein	<input type="radio"/> Normal	<input type="radio"/> Abnormal

Cholesterol Profile					
Cholesterol Total	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Cholesterol-HDL	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Triglycerides	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Cholesterol-LDL	<input type="radio"/> Normal	<input type="radio"/> Abnormal


Renal Function					
Urea	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Potassium	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Uric Acid	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Sodium	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Creatinine	<input checked="" type="radio"/> Normal	<input type="radio"/> Abnormal	Chloride	<input type="radio"/> Normal	<input type="radio"/> Abnormal

### Comments on Abnormal Results

## J. MEDICAL FITNESS FOR WORK RECOMMENDATION

<b>Fit for Work</b>	Fit For Work
<b>Fit with restrictions</b>	-----
<b>Unfit for Work</b>	-----

## K. DETAILS OF EXAMINING MEDICAL PRACTITIONER

<b>NAME</b> DRA. SARA JIMENEZ
<b>CLINIC OR PRACTICE NAME</b> CENTRO INTEGRAL DE SALUD MAIMON
<b>PHYSICAL ADDRESS</b> REPUBLICA DOMINICA,MONSEÑOR NOUEL, C/ DUARTE N 113, MAIMON
<b>TELEPHONE CONTACT NUMBERS</b> 809-551-2196
<b>EMAIL ADDRESS</b> SALUD@CISAM.COM .DO
<div> <div>SIGNATURE</div> <div>  <div> Dra. Sara Jiménez  Médico Ocupacional  Sexóloga • EXQ: 342-92 </div> </div> </div> <div> <div>DATE</div> <div>7/8/2023</div> </div> <div> <div>STAMP WITH REGISTRATION NUMBER</div> <div></div> </div>

## Boletim de Vacinas

Nome: PAULO MIGUEL MACHADO CALDEIRA

Data de nascimento: 17/04/1978

Nº utente de saúde: 392910839

Próxima inoculação: a partir de 11/02/2029

### Prova Tuberculínica

01/06/1988

### Vacina contra a COVID-19

25/06/2021

12/12/2021

### Vacina contra a Difteria

De 11/02/2029 a 11/02/2030

### Vacina contra a Difteria e o Tétano

28/11/1983

11/02/2009

### Vacina contra a Difteria, Tétano, Tosse Convulsa (pertussis célula completa)

01/08/1979

06/09/1979

22/10/1979

22/10/1980

### Vacina contra a Gripe

23/10/2020

Legenda:

Administrada

Em atraso

Futura

### Vacina contra a Hepatite B

03/11/1993

06/12/1993

23/05/1994

23/06/1998

### Vacina contra a Poliomielite

01/08/1979

22/10/1979

04/06/1980

12/06/1981

28/11/1983

02/03/1988

### Vacina contra a tuberculose

27/07/1985

### Vacina contra o Sarampo, a Papeira e a Rubéola

04/11/1991

### Vacina contra o Tétano

02/03/1988

23/06/1998

De 11/02/2029 a 11/02/2030

### Vacina viva contra o Sarampo

02/04/1980

Legenda

Administrada

Em atraso

Futura



URCI: URN:UVCI:01:PT:MS:RSEBK4SP5U1WD5OOY5RA#B



REPÚBLICA  
PORTUGUESA  
SAÚDE



SNS  
SERVIÇO NACIONAL  
DE SAÚDE

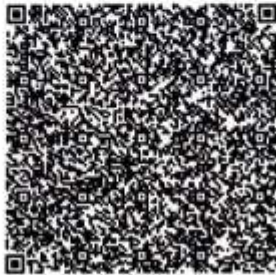


CERTIFICADO DIGITAL COVID DA UE  
EU DIGITAL COVID CERTIFICATE

Este certificado não é um documento de viagem. As evidências consistem no registo de vacinação, teste e recuperação da COVID-19, continuando a evoluir, também em função de novas variantes preocupantes do vírus. Antes de viajar, consulte as medidas de saúde pública aplicáveis e as restrições existentes no local de destino.

This certificate is not a travel document. The scientific evidence on COVID-19 vaccination, testing and recovery continues to evolve, also in view of new variants of concern of the virus. Before travelling, please check the applicable public health measures and related restrictions applied at the point of destination.

## CERTIFICADO DE VACINAÇÃO VACCINATION CERTIFICATE



## IDENTIFICAÇÃO DO UTENTE PERSON IDENTIFICATION

APELIDO(S) / SURNAME(S)

MACHADO CALDEIRA

NOME(S) / FORENAME(S)

PAULO MIGUEL

DATA DE NASCIMENTO / DATE OF BIRTH

18-04-1978

## INFORMAÇÃO VACINAÇÃO VACCINATION INFORMATION

DOENÇA OU AGENTE / DISEASE OR AGENT TARGETED

COVID-19

VACINA/PROFILAXIA / VACCINE/PROPHYLAXIS

Vacina COVID-19 (mRNA)

PRODUTO MEDICO VACINAL / VACCINE MEDICINAL PRODUCT

Covid-19 Vaccine Moderna

TITULAR DA AUTORIZAÇÃO DE INTRODUÇÃO NO MERCADO OU FABRICANTE DA VACINA  
VACCINE MARKETING AUTHORISATION HOLDER OR MANUFACTURER

Moderna Biotech Spain, S.L.

NÚMERO DA DOSE ADMINISTRADA E NÚMERO TOTAL DE DOSES DO ESQUEMA VACINAL  
NUMBER IN A SERIES OF VACCINATIONS / DOSES AND THE OVERALL NUMBER OF DOSES IN THE SERIES

2/1

DATA DE VACINAÇÃO / DATE OF VACCINATION

12-12-2021

ESTADO MEMBRO DE VACINAÇÃO / MEMBER STATE OF VACCINATION

PT

## METADADOS DO CERTIFICADO CERTIFICATE METADATA

ENTIDADE EMISSORA / CERTIFICATE ISSUER

Ministério da Saúde

IDENTIFICADOR ÚNICO DO CERTIFICADO (UVCI) / UNIQUE CERTIFICATE IDENTIFIER

URN:UVCI:01:PT:MS:RSEBK4SP5U1WD5OOY5RA#B

Este documento é válido até ao dia 22-04-2024 (inclusive) e pode ser renovado através do Portal SNS24 ou da aplicação móvel SNS24.  
This document is valid until 22-04-2024 (including) and it can be renewed through SNS24 Website or SNS24 mobile app.

Para mais informação consulte: <https://www.sns24.gov.pt/guia/certificado-digital-covid-da-ue/>  
Relevant information can be found here: <https://www.sns24.gov.pt/guia/certificado-digital-covid-da-ue/>

**CERTIFICADO DIGITAL COVID DA UE / EU DIGITAL COVID CERTIFICATE**

Este certificado não é um documento de viagem. As evidências científicas sobre a vacinação, teste e recuperação da COVID-19 continuam a evoluir, também em função de novas variantes preocupantes do vírus. Antes de viajar, verifique as medidas de saúde pública aplicáveis e as restrições existentes no local de destino.

This certificate is not a travel document. The scientific evidence on COVID-19 vaccination, testing and recovery continues to evolve, also in view of new variants of concern of the virus. Before travelling, please check the applicable public health measures and related restrictions applied at the point of destination.

**CERTIFICADO DE VACINAÇÃO  
VACCINATION CERTIFICATE****IDENTIFICAÇÃO DO UTENTE  
PERSON IDENTIFICATION**

APELIDO(S) / SURNAME(S)

MACHADO CALDEIRA

NOME(S) / FORENAME(S)

PAULO MIGUEL

DATA DE NASCIMENTO / DATE OF BIRTH

18-04-1978

**INFORMAÇÃO VACINAÇÃO  
VACCINATION INFORMATION**

DOENÇA OU AGENTE / DISEASE OR AGENT TARGETED

COVID-19

VACINA/PROFILAXIA / VACCINE/PROPHYLAXIS

Vacina COVID-19 (antigénio)

PRODUTO MÉDICO VACINAL / VACCINE MEDICINAL PRODUCT

COVID-19 Vaccine Janssen

TITULAR DA AUTORIZAÇÃO DE INTRODUÇÃO NO MERCADO OU FABRICANTE DA VACINA  
VACCINE MARKETING AUTHORISATION HOLDER OR MANUFACTURER

Janssen-Cilag International

NÚMERO DA DOSE ADMINISTRADA E NÚMERO TOTAL DE DOSES DO ESQUEMA VACINAL  
NUMBER IN A SERIES OF VACCINATIONS / DOSES AND THE OVERALL NUMBER OF DOSES IN THE SERIES

1/1

DATA DE VACINAÇÃO / DATE OF VACCINATION

25-06-2021

ESTADO MEMBRO DE VACINAÇÃO / MEMBER STATE OF VACCINATION

PT

**METADADOS DO CERTIFICADO  
CERTIFICATE METADATA**

ENTIDADE EMISSORA / CERTIFICATE ISSUER

Ministério da Saúde

IDENTIFICADOR ÚNICO DO CERTIFICADO (UVC1) / UNIQUE CERTIFICATE IDENTIFIER

URN:UVC1:01:PT:MS:RSEB080JU8VP8QC41FSM#1

Para mais informação consulte <https://reopen.europe.eu/pt> / Relevant information can be found here <https://reopen.europe.eu/en>



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# PROTECCIÓN ADICIONAL CONTRA EL VIRUS DE LA INFLUENZA



## CONTROL DE VACUNACIÓN

FARMACIA

NOMBRE

EDAD

CEDULA

TELÉFONO

Paulo meque machado C

umi: 119793

Pasaporte: C4697740



Este certificado tiene validez solamente cuando la vacuna haya sido aprobada por la Organización Mundial de la Salud y administrada en un puesto de vacunación habilitado o acreditado por el Ministerio de Salud Pública.

El Certificado de vacunación contra la fiebre amarilla tiene validez por (diez) 10 años, contando a partir del décimo día después de la fecha de la vacunación o revacunación. Cualquier alteración, aunque a menudo afectará la validez de este certificado.

This Certificate is valid only if the vaccine used has been approved by the World Health Organization and if the vaccinating center has been designated by the health administration for the territory in which that center is situated.

The validity of this certificate shall extend for a period of ten years, beginning ten days after the date of vaccination or in the event of a revaccination. Any amendment of this certificate, or errors, of failure to complete any part of it, may render it invalid.

Ce Certificat n'est valable que si le vaccin employé a été approuvé par l'Organisation Mondiale de la Santé et si le centre de vaccination est habilité par l'administration sanitaire du territoire dans lequel ce centre est situé.

La validité de ce certificat couvre une période de dix ans commençant dix jours après la date de la vaccination ou d'une revaccination au cours de cette période de dix ans, le jour de cette revaccination. Toute correction ou retouches sur le certificat ou l'omission d'une quelconque dans mentions qu'il comporte peut affecter sa validité.

República Dominicana  
MINISTERIO DE SALUD PÚBLICA

PROGRAMA AMPLIADO DE INMUNIZACION



Organización Mundial de la Salud  
World Health Organization  
Organisation Mondiale de la Santé



CERTIFICADO INTERNACIONAL DE VACUNACION  
INTERNATIONAL CERTIFICATE OF VACCINATION  
CERTIFICAT INTERNATIONAL DE VACCINATION