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**MED-STOP MRO SERVICES**  
**9950 LAWRENCE AVE STE 403**  
**SCHILLER PARK IL 60176**  
**PHONE: (877) 633-3633**  
**FAX: (847) 647-6608**  
**EMAIL: mro@med-stop.com**

# MRO RESULT

**TO:**

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**ZIGI FREIGHT INC**  
**6850 W 63RD STREET**  
**CHICAGO IL 60638**  
**PHONE: (630) 485-7370**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

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**NIKOLA STAMENKOVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**11/27/2023 10:19 AM CST UTC-6**

**PAGES:**

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**2**

**THIS SECURE FAX NUMBER HAS BEEN PROVIDED TO MED-STOP MRO SERVICES BY EMPLOYERS  
REPRESENTATIVE IDENTIFIED AS SAFETY OFFICER**

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**PLEASE FORWARD TO THE SAFETY OFFICER**

**CONFIDENTIAL**

**RESULTS OF SAMSHA (NIDA) CONTROLLED TEST**

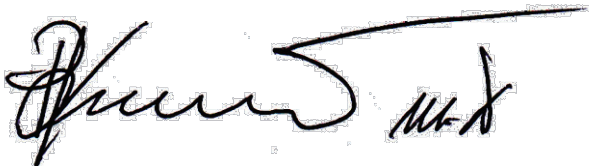
PURPOSE OF TEST:	SPECIMEN ID:	MED-STOP MRO SERVICES
<b>PRE-EMPLOYMENT</b>	<b>CF15807543</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>11/14/2023 12:03 PM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>CST UTC-6</b>		<b>FAX: (847) 647-6608</b>
TEST RESULT:		<b>EMAIL: mro@med-stop.com</b>

**NEGATIVE**

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

**EMPLOYEE / APPLICANT:**  
**GEFFRARD, CHRISTIAL****DONOR ID:**  
**FLG166100834060****NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC****6850 W 63RD STREET**  
**CHICAGO IL 60638****LOCATION / COLLECTION SITE:**  
**MED-STOP HICKORY HILLS**  
**7831 W 95TH ST**  
**HICKORY HILLS IL 60457**  
**PHONE: (708) 546-0551****LABORATORY PERFORMING TEST:**  
**CLINICAL REFERENCE LABORATORY**  
**8433 QUIVIRA**  
**LENEXA KS 66215**  
**PHONE: (800) 452-5677****MEDICAL REVIEW OFFICER:**  
**KWIECINSKI PAWEL K****SIGNATURE:****LAB RESULT RECEIVED AT:**  
**11/15/2023 10:43 AM CST UTC-6****MRO COPY BECAME AVAILABLE AT:**  
**11/14/2023 12:05 PM CST UTC-6****DATE / TIME THE RESULT BECAME AVAILABLE:**  
**11/15/2023 10:48 AM CST UTC-6**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 5 8 0 7 5 4 3

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D2828543

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

A. Employer Name, Address, I.D. No.

NIKOLA STAMENKOVIC  
ZIGI FREIGHT INC  
6850 W 63RD ST  
CHICAGO, IL 60638  
Phone#: (630)485-7370 / Fax#: (630)485-6980

Site Location

**FL G166100834060**

B. MRO Name, Address, Phone No. and Fax No.

PAWEL KWIECINSKI, MD (MRO4478)  
MED-STOP INC  
9950 LAWRENCE AVE  
SUITE 403  
SCHILLER PARK, IL 60176  
Phone#: (877)633-3633 / Fax#: (847)647-6608

C. Donor SSN, Employee I.D. No., or CDL State and No.

D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG  
E. Reason for Test: ☒ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) \_\_\_\_\_  
F. Drug Tests to be Performed: ☒ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) \_\_\_\_\_  
**W215**G. Collection Site Address: **Med Stop - Hickory Hills****7831 W 95th St Ste J****Hickory Hills, IL 60457-2388**

Collection Site Code:

**YMS.0003**Collector Contact Info: Phone **(708)546-0551**Fax **(708)295-9162**Other **info@med-stop.com****STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).**☒ **URINE**☐ **ORAL FLUID**COLLECTION: ☒ Split ☐ Single ☐ None Provided, Enter Remark.**URINE: Collector reads urine temperature within 4 minutes.** Temperature between 90° and 100°F? ☒ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark**ORAL FLUID:** Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS:

**STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)****STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY***I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable federal requirements.***X**   
Signature of Collector  
Dorota Moniuszko  
(PRINT) Collector's Name (First, MI, Last)  
11/14/2023  
Date (Mo/DaY/Yr)  
12:03 CST PM **X**  
Time of Collection**SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:**☐ UPS☐ FedEx☒ Other **CRL Courier**

Name of Delivery Service

**STEP 5: COMPLETED BY DONOR***I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle/tube used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle/tube is correct.***X**   
Signature of Donor  
CHRISTIAL GEFFRARD  
(PRINT) Donor's Name (First, MI, Last)  
11/14/2023  
Date (Mo/DaY/Yr)  
11/6/1983  
Date of Birth (Mo/DaY/Yr)  
Email address: **N/A** Daytime Phone No. **3522725213** Evening Phone No. **3522725213**

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). - DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

**STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN**☒ **URINE**☐ **ORAL FLUID***In accordance with applicable federal requirements, my verification is:*☐ **NEGATIVE** ☐ **POSITIVE** for: \_\_\_\_\_  
☐ **DILUTE**  
☐ **REFUSAL TO TEST** because - check reason(s) below: ☐ **TEST CANCELLED**  
☐ **ADULTERATED** (adulterant/reason): \_\_\_\_\_  
☐ **SUBSTITUTED**  
☐ **OTHER:** \_\_\_\_\_

REMARKS: \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/DaY/Yr)**STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN***In accordance with applicable federal requirements, my verification for the split specimen (if tested) is:*☐ **RECONFIRMED** for: \_\_\_\_\_ ☐ **TEST CANCELLED**  
☐ **FAILED TO RECONFIRM** for: \_\_\_\_\_

REMARKS: \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/DaY/Yr)

COPY 2 - MEDICAL REVIEW OFFICER COPY