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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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**11/29/2023 02:32 PM 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>CF14328084</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>11/27/2023 02:56 PM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>EST UTC-5</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:  
**HERNANDEZ OFARRIL, JUAN GABRIEL**

NAME OF COMPANY / LOCATION:  
**ZIGI FREIGHT INC**

DONOR ID:  
**FLH655426671050**

**6850 W 63RD STREET**  
**CHICAGO IL 60638**

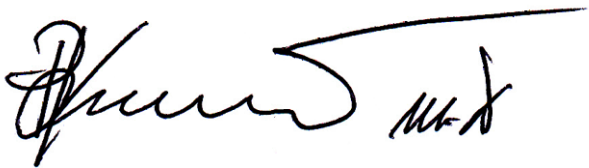
LOCATION / COLLECTION SITE:  
**ARCPOINT LABS OF FORT LAUDER**  
**3221 NW 10TH TER STE 508**  
**FT LAUDERDALE FL 33309-5942**  
**PHONE: (954) 667-7908**

LABORATORY PERFORMING TEST:  
**CLINICAL REFERENCE LABORATORY**  
**8433 QUIVIRA**  
**LENEXA KS 66215**  
**PHONE: (800) 452-5677**

MEDICAL REVIEW OFFICER:  
**KWIECINSKI PAWEL K**

LAB RESULT RECEIVED AT:  
**11/28/2023 11:41 AM CST UTC-6**

SIGNATURE:



MRO COPY BECAME AVAILABLE AT:  
**11/27/2023 02:00 PM CST UTC-6**

DATE / TIME THE RESULT BECAME AVAILABLE:  
**11/28/2023 11:44 AM CST UTC-6**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





Marketplace

8433 Quivira Road  
Lenexa, KS 66215

C F 1 4 3 2 8 0 8 4

SPECIMEN ID NO.

CLIENT NO. YMS.CMKT.D2828543

ACCESSION NO.

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

<b>A. Employer Name, Address, I.D. No.</b> NIKOLA STAMENKOVIC ZIGI FREIGHT INC 6850 W 63RD ST CHICAGO, IL 60638 Phone#: (630)485-7370 / Fax#: (630)485-6980	<b>Site Location</b>  <div style="border: 1px solid black; padding: 5px; text-align: center;"><b>FLH655426671050</b></div>	<b>B. MRO Name, Address, Phone No. and Fax No.</b> PAWEL KWIECINSKI, MD (MRO4478) MED-STOP INC 9950 LAWRENCE AVE SUITE 403 SCHILLER PARK, IL 60176 Phone#: (877)633-3633 / Fax#: (847)647-6608
<b>C. Donor SSN, Employee I.D. No., or CDL State and No.</b>		
<b>D. Specify Testing Authority:</b> <input type="checkbox"/> HHS <input type="checkbox"/> NRC <b>Specify DOT Agency:</b> <input checked="" type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG		
<b>E. Reason for Test:</b> <input checked="" type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____		
<b>F. Drug Tests to be Performed:</b> <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ <div style="text-align: center;"><b>W215</b></div>		
<b>G. Collection Site Address:</b> <b>ARCpoint Labs of Fort</b> <b>3221 NW 10th Ter Ste 508</b> <b>Ft Lauderdale, FL 33309-5942</b>	<b>Collection Site Code:</b> <div style="border: 1px solid black; padding: 5px; text-align: center;"><b>FGF.FORT</b></div>	<b>Collector Contact Info:</b> Phone <b>(954)667-7908</b> Fax <b>(954)951-1539</b> Other <b>MLasso@arcpointlabs.com</b>

**STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).**☒ URINE☐ ORAL FLUID

<b>COLLECTION:</b> <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.	
<b>URINE: Collector reads urine temperature within 4 minutes.</b> Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark	
<b>ORAL FLUID:</b> Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided	Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed
<b>REMARKS:</b>	

**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.*

<b>X</b> Signature of Collector Daniel Oudkerk (PRINT) Collector's Name (First, MI, Last)	11/27/2023 Date (Mo/Day/Yr)	2:56 EST PM <b>X</b> Time of Collection	<b>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</b> <input type="checkbox"/> UPS <input checked="" type="checkbox"/> FedEx <input type="checkbox"/> Other _____ Name of Delivery Service
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**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.*

<b>X</b> Signature of Donor	<b>JUAN G HERNANDEZ OFARRIL</b> (PRINT) Donor's Name (First, MI, Last)	11/27/2023 Date (Mo/Day/Yr)
Email address: N/A Daytime Phone No. 6304857370 Evening Phone No. 6304857370 Date of Birth 3/25/1967 (Mo/Day/Yr)		

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

<i>In accordance with applicable federal requirements, my verification is:</i>	
<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE for: _____ <input type="checkbox"/> DILUTE	
<input type="checkbox"/> REFUSAL TO TEST because - check reason(s) below: <input type="checkbox"/> ADULTERATED (adulterant/reason): _____ <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> TEST CANCELLED
<b>REMARKS:</b> <b>X</b>	
Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)

**STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN**

*In accordance with applicable federal requirements, my verification for the split specimen (if tested) is:*

<input type="checkbox"/> RECONFIRMED for: _____ <input type="checkbox"/> FAILED TO RECONFIRM for: _____	<input type="checkbox"/> TEST CANCELLED
<b>REMARKS:</b> <b>X</b>	
Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)

COPY 2 - MEDICAL REVIEW OFFICER COPY

OMB No. 0930-0158