



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:

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

ATTENTION TO:

NIKOLA STAMENKOVIC

SUBJECT:

URINE DRUG TESTING RESULTS

DOCUMENT CREATED AT:

12/11/2023 12:43 PM CST UTC-6

PAGES:

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

PLEASE FORWARD TO THE SAFETY OFFICER

CONFIDENTIAL

RESULTS OF SAMSHA (NIDA) CONTROLLED TEST

PURPOSE OF TEST:	SPECIMEN ID:	MED-STOP MRO SERVICES
PRE-EMPLOYMENT	CF14328109	9950 LAWRENCE AVE STE 403
COLLECTION DATE / TIME:	TESTING AUTHORITY:	SCHILLER PARK IL 60176
12/08/2023 01:42 PM	DOT FMCSA	PHONE: (877) 633-3633
EST UTC-5		FAX: (847) 647-6608
TEST RESULT:		EMAIL: mro@med-stop.com

NEGATIVE

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
BATELUS, LUMENES**DONOR ID:**
FLB342520800260**NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC**
6850 W 63RD STREET
CHICAGO IL 60638**LOCATION / COLLECTION SITE:**
ARCPPOINT 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**SIGNATURE:****LAB RESULT RECEIVED AT:**
12/09/2023 03:54 PM CST UTC-6**MRO COPY BECAME AVAILABLE AT:**
12/08/2023 12:45 PM CST UTC-6**DATE / TIME THE RESULT BECAME AVAILABLE:**
12/11/2023 08:05 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 1 0 9

SPECIMEN ID NO.

CLIENT NO. YMS.CMKT.D2828543

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

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 	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
FLB342520800260		
C. Donor SSN, Employee I.D. No., or CDL State and No. 		
D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <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		
E. Reason for Test: <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) _____		
F. Drug Tests to be Performed: <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ W215		
G. Collection Site Address: ARCpoint Labs of Fort 3221 NW 10th Ter Ste 508 Ft Lauderdale, FL 33309-5942	Collection Site Code: FGF.FORT	Collector Contact Info: Phone (954)667-7908 Fax (954)951-1539 Other MLasso@arcpointlabs.com

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

COLLECTION: <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.	
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark	
ORAL FLUID: 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
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 Daniel Oudkerk (PRINT) Collector's Name (First, MI, Last)	12/8/2023 Date (Mo/Day/Yr)	1:42 EST PM X Time of Collection	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: <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.

X Signature of Donor	LUMENES BATELUS (PRINT) Donor's Name (First, MI, Last)	12/8/2023 Date (Mo/Day/Yr)
Email address: lumenes52@gmail.com Daytime Phone No. 6304857370 Evening Phone No. 6304857370 Date of Birth 1/26/1980 (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

In accordance with applicable federal requirements, my verification is: <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"/> TEST CANCELLED <input type="checkbox"/> ADULTERATED (adulterant/reason): _____ <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> 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:

<input type="checkbox"/> RECONFIRMED for: _____ <input type="checkbox"/> FAILED TO RECONFIRM for: _____	<input type="checkbox"/> TEST CANCELLED
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

OMB No. 0930-0158