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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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**12/28/2023 11:26 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:

**PRE-EMPLOYMENT**

COLLECTION DATE / TIME:

**12/19/2023 11:25 AM****CST UTC-6**

TEST RESULT:

**NEGATIVE**

SPECIMEN ID:

**CF15808634**

TESTING AUTHORITY:

**DOT FMCSA****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**

TEST LAB PANEL:

**W215**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:

**DA SILVA, FLAVIO MARCAL**

DONOR ID:

**FLD241253642230**

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**

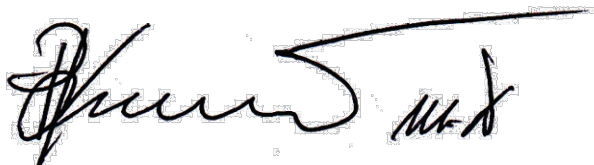
LABORATORY PERFORMING TEST:

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

MEDICAL REVIEW OFFICER:

**KWIECINSKI PAWEL K**

SIGNATURE:



LAB RESULT RECEIVED AT:

**12/20/2023 09:36 AM CST UTC-6**

MRO COPY BECAME AVAILABLE AT:

**12/19/2023 11:30 AM CST UTC-6**

DATE / TIME THE RESULT BECAME AVAILABLE:

**12/20/2023 09:37 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 8 6 3 4

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.

Site Location

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

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

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

**FL D241253642230**

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**

Collection Site Code:

Collector Contact Info: Phone **(708)546-0551****7831 W 95th St Ste J****YMS.0003**Fax **(708)295-9162****Hickory Hills, IL 60457-2388**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 RemarkORAL 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  
Krystyna Rojek-Lampe 12/19/2023 11:25 CST PM **X**  
(PRINT) Collector's Name (First, MI, Last) Date (Mo/DaY/Yr) 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  
FLAVIO M DA SILVA 12/19/2023  
(PRINT) Donor's Name (First, MI, Last) Date (Mo/DaY/Yr)  
Email address: N/A Daytime Phone No. 8137868630 Evening Phone No. 8137868630 Date of Birth 6/23/1964  
(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:

☐ 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

OMB No. 0930-0158