



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:

01/15/2024 08:48 AM 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	7939975810	9950 LAWRENCE AVE STE 403
COLLECTION DATE / TIME:	TESTING AUTHORITY:	SCHILLER PARK IL 60176
01/12/2024 05:24 PM	DOT FMCSA	PHONE: (877) 633-3633
EST UTC-5		FAX: (847) 647-6608
TEST RESULT:		EMAIL: mro@med-stop.com

NEGATIVE

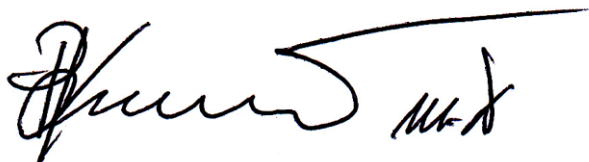
TEST LAB PANEL:

65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:	NAME OF COMPANY / LOCATION:
MORALES CAPOTE, REINERIO	ZIGI FREIGHT INC
DONOR ID:	6850 W 63RD STREET
FLM642270860060	CHICAGO IL 60638

LOCATION / COLLECTION SITE:	LABORATORY PERFORMING TEST:
XPRESS URG CARE - MARGATE	QUEST DIAGNOSTICS
6101 W ATLANTIC BLVD	10101 RENNER BLVD
MARGATE FL 33063	LENEXA KS 66219
PHONE: (954) 869-4320	PHONE: (866) 697-8378

MEDICAL REVIEW OFFICER:	LAB RESULT RECEIVED AT:
KWIECINSKI PAWEL K	01/13/2024 06:33 PM CST UTC-6
SIGNATURE:	MRO COPY BECAME AVAILABLE AT:
	01/13/2024 06:35 PM CST UTC-6
	DATE / TIME THE RESULT BECAME AVAILABLE:
	01/15/2024 08:12 AM CST UTC-6

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 7939975810



OMB No. 0930-0158

STEP 1 : COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. ZIGI FREIGHT INC 6850 W 63RD STREET CHICAGO, IL 60638 Phone: 630-485-7370 Fax: 630-485-6980		Lab Acct #: 10624350 TESTING AUTHORITY: FMCSA ACCOUNT NUMBER: 501512218129	B. MRO Name, Address, Phone and Fax No. PAWEL KWIECINSKI MD 9950 LAWRENCE AVE STE 403 SCHILLER PARK, IL 60176 Phone: 847-647-0453 Fax: 847-647-6608
C. Donor SSN, Employee I.D., or CDL State and No. FLM642270860060			
D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC <input checked="" type="checkbox"/> 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) _____			
G. Collection Site Address: Xpress Urg Care - Margate - 55106 6101 W Atlantic Blvd Ste 101 Margate, FL 33063		Collector Contact Info: Phone 954-869-4320 Fax 954-869-4625 Other _____	55106-FL092 Clinic ID

STEP 2 : COMPLETED BY COLLECTOR (make remarks when appropriate).

Collection: <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark _____	<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID
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 _____ 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: DER Name: IANACHI ELENA	

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.		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
X	Signature of Collector NATHALY PRIETO (PRINT) Collector's Name (First, MI, Last)	FEDEX Name of Delivery Service
	01 / 12 / 2024 Date (Mo./Day/Yr.)	
	5:24:45 Time of Collection	
	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	

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 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 is correct.	
X	Signature of Donor REINERIO MORALES CAPOTE (PRINT) Donor's Name (First, MI, Last)
	01 / 12 / 2024 Date (Mo./Day/Yr.)
	01 / 06 / 1986 Date (Mo./Day/Yr.)
	Email _____ Day Phone (786) 477-0153 Evening Phone () Not Provided Date of Birth
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

<input checked="" type="checkbox"/> URINE <input type="checkbox"/> 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"/> TEST CANCELLED
<input type="checkbox"/> FAILED TO RECONFIRM for: _____
REMARKS: _____
X
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)