



---

**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:**

---

**RIKI TRANSPORTATION INC**  
**8225 LECLAIRE AVE**  
**BURBANK IL 60459**  
**PHONE: (973) 563-3159**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

---

**RADOSLAV KOVACEVIC**

**SUBJECT:**

---

**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

---

**02/08/2024 02:52 PM CST UTC-6**

**PAGES:**

---

**2**

**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
<b>PRE-EMPLOYMENT</b>	<b>CF14328205</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>01/29/2024 12:10 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:**  
**SMITH, EVEROY ALBERT****DONOR ID:**  
**FLS530201720070****NAME OF COMPANY / LOCATION:**  
**RIKI TRANSPORTATION INC****8225 LECLAIRE AVE**  
**BURBANK IL 60459****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:**  
**01/30/2024 12:41 PM CST UTC-6****MRO COPY BECAME AVAILABLE AT:**  
**01/29/2024 11:15 AM CST UTC-6****DATE / TIME THE RESULT BECAME AVAILABLE:**  
**01/30/2024 12:46 PM 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 2 0 5

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

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

ACCESSION NO.

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

KOVACEVIC RADOSLAV  
RIKI TRANSPORTATION INC  
8225 LECLAIRE AVE  
BURBANK, IL 60459  
Phone#: (973)563-3159 / 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**FLS530201720070**

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: **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: ☒ 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

Abby Smith

1/29/2024

12:10 EST 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 \_\_\_\_\_

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

EVEROY A SMITH

(PRINT) Donor's Name (First, MI, Last)

1/29/2024

Date (Mo/DaY/Yr)

1/7/1972

(Mo/DaY/Yr)

Email address: **N/A** Daytime Phone No. **7547795441** Evening Phone No. **7547795441** 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**☒ **URINE**☐ **ORAL FLUID**

In accordance with applicable federal requirements, my verification is:

☐ **NEGATIVE**☐ **POSITIVE for:** \_\_\_\_\_☐ **DILUTE**☐ **REFUSAL TO TEST because - check reason(s) below:**☐ **ADULTERATED (adulterant/reason):** \_\_\_\_\_☐ **SUBSTITUTED**☐ **OTHER:** \_\_\_\_\_☐ **TEST CANCELLED**

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