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:

02/16/2024 11:46 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:
PRE-EMPLOYMENT

SPECIMEN ID:
7941060699

COLLECTION DATE / TIME:
01/30/2024 08:59 AM EST UTC-5

TESTING AUTHORITY:
DOT FMCSA

TEST RESULT:
NEGATIVE

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:
65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
DEL TORO BESTARD, JOSE MIGUEL

DONOR ID:
FLD436433734020

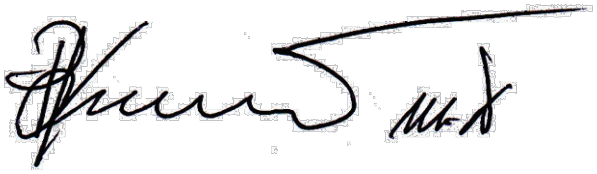
NAME OF COMPANY / LOCATION:
RIKI TRANSPORTATION INC
8225 LECLAIRE AVE
BURBANK IL 60459

LOCATION / COLLECTION SITE:
LEE CONV CARE - PINE ISL
1682 NE PINE ISLAND RD
CAPE CORAL FL 33909
PHONE: (239) 424-1656

LABORATORY PERFORMING TEST:
QUEST DIAGNOSTICS
10101 RENNER BLVD
LENEXA KS 66219
PHONE: (866) 697-8378

MEDICAL REVIEW OFFICER:
KWIECINSKI PAWEL K

SIGNATURE:



LAB RESULT RECEIVED AT:
01/31/2024 02:33 PM CST UTC-6

MRO COPY BECAME AVAILABLE AT:
01/31/2024 02:35 PM CST UTC-6

DATE / TIME THE RESULT BECAME AVAILABLE:
01/31/2024 02:43 PM 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. **7941060699**

Quest Diagnostics™ 800-877-7484

OMB No. 0930-0158

STEP 1 : COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

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

RIKI TRANSPORTATION INC
8225 LECLAIRE AVE
BURBANK, IL 60459
Phone: 973-563-3159 Fax: 630-485-6980

Lab Acct #: 10783041
TESTING AUTHORITY FMCSA
ACCOUNT NUMBER: 50180822235933

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. FLD436433734020

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) _____

G. Collection Site Address:

Lee Conv Care - Pine Isl - 25058
1682 NE PINE ISLAND RD
CAPE CORAL, FL 33909

25058-FL648
Clinic ID

Collector Contact Info: Phone 239-424-1656
Fax 239-424-1655
Other _____

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: DER Name: DER

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

Diane Callaghan — (PRINT) Collector's Name (First, MI, Last)
01 / 30 / 2024 — Date (Mo./Day/Yr.)
8:59:16 — Time of Collection
☑ AM ☐ PM

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

FEDEX — 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 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 _____ JOSE M DEL TORO BESTARD — 01 / 30 / 2024
Signature of Donor | (PRINT) Donor's Name (First, MI, Last) | Date (Mo./Day/Yr.)

Email _____ Day Phone (786) 337-1389 Evening Phone (___) Not Provided Date of Birth 11 / 02 / 1973 (Date (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.)