



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:

02/21/2024 02:16 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	CF15810009	9950 LAWRENCE AVE STE 403
COLLECTION DATE / TIME:	TESTING AUTHORITY:	SCHILLER PARK IL 60176
02/05/2024 02:26 PM	DOT FMCSA	PHONE: (877) 633-3633
CST UTC-6		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:
PAEZ SOLER, YASSER ELISEIEV

DONOR ID:
FLP246965894280

NAME OF COMPANY / LOCATION:
ZIGI FREIGHT INC

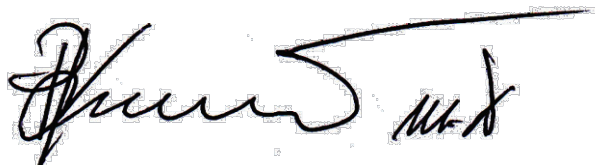
6850 W 63RD STREET
CHICAGO IL 60638

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:
02/06/2024 10:25 AM CST UTC-6

MRO COPY BECAME AVAILABLE AT:
02/05/2024 02:30 PM CST UTC-6

DATE / TIME THE RESULT BECAME AVAILABLE:
02/06/2024 10:39 AM CST UTC-6

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 5 8 1 0 0 0 9

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)485-6980PAWEL KWIECINSKI, MD (MRO4478)
MED-STOP INC
9950 LAWRENCE AVE
SUITE 403
SCHILLER PARK, IL 60176
Phone#: (877)633-3633 / Fax#: (847)647-6608**FL P246965894280**

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 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.*

<input checked="" type="checkbox"/>	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
	<input type="checkbox"/> UPS	<input type="checkbox"/> FedEx
Signature of Collector	<input checked="" type="checkbox"/> Other <u>CRL Courier</u>	
Agnieszka Horodowicz	2/5/2024	2:26 CST PM <input checked="" type="checkbox"/>
(PRINT) Collector's Name (First, MI, Last)	Date (Mo/Day/Yr)	Time of Collection
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.*

<input checked="" type="checkbox"/>	YASSER E PAEZ SOLER	2/5/2024
Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr)
Email address: <u>mr.ypaez@gmail.com</u>	Daytime Phone No. <u>5619700192</u>	Evening Phone No. <u>5619700192</u> Date of Birth <u>11/28/1989</u>
(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: _____

☒ _____
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: _____

☒ _____
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/Day/Yr)

COPY 2 - MEDICAL REVIEW OFFICER COPY