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

**ATTENTION TO:**

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**RADOSLAV KOVACEVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**03/05/2024 03:11 PM 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:	SPECIMEN ID:	MED-STOP MRO SERVICES
<b>PRE-EMPLOYMENT</b>	<b>CF14085450</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>02/16/2024 11:50 AM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>CST UTC-6</b>		<b>FAX: (847) 647-6608</b>
TEST RESULT:		<b>EMAIL: mro@med-stop.com</b>

**NEGATIVE**

TEST LAB PANEL:

65304N

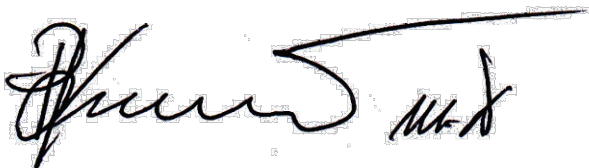
THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:	NAME OF COMPANY / LOCATION:
<b>RODAS LOPEZ, GABRIEL ALFONSO</b>	<b>RIKI TRANSPORTATION INC</b>
DONOR ID:	<b>8225 LECLAIRE AVE</b>
<b>AR942221032</b>	<b>BURBANK IL 60459</b>

LOCATION / COLLECTION SITE:	LABORATORY PERFORMING TEST:
<b>COURTHOUSE CONCEPTS, INC. - FA</b>	<b>QUEST DIAGNOSTICS</b>
<b>4250 N VENETIAN LN</b>	<b>10101 RENNER BLVD</b>
<b>FAYETTEVILLE AR 72703-5077</b>	<b>LENEXA KS 66219</b>
<b>PHONE: (479) 582-3660</b>	<b>PHONE: (866) 697-8378</b>

MEDICAL REVIEW OFFICER:	LAB RESULT RECEIVED AT:
<b>KWIECINSKI PAWEL K</b>	<b>02/17/2024 01:17 PM CST UTC-6</b>

SIGNATURE:



MRO COPY BECAME AVAILABLE AT:
<b>02/16/2024 11:55 AM CST UTC-6</b>

DATE / TIME THE RESULT BECAME AVAILABLE:
<b>02/17/2024 01:36 PM CST UTC-6</b>

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 4 0 8 5 4 5 0

SPECIMEN ID NO.

CLIENT NO. 10783041

**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.

 RIKI TRANSPORTATION INC  
 8225 LECLAIRE AVE RADOSLAV KOVACEVIC  
 BURBANK, IL 60459

Phone#: (973)563-3159 Fax#: (630)485-6980

PAWEL KWIECINSKI MD

 9950 LAWRENCE AVE STE 403 MED STOP INC  
 SCHILLER PARK, IL 60176  
 Phone#: (847)647-0453 Fax#: (847)647-6608

C. Donor SSN, Employee I.D. No., or CDL State and No.

**AR942221032**D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCGE. 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) \_\_\_\_\_**65304N**ACCOUNT NUMBER: : **50180822235933**G. Collection Site Address: **CourtHouse Concepts, Inc. -**

Collection Site Code:

Collector Contact Info: Phone **(479)582-3660****4250 N Venetian Ln****AR732**Fax **(479)582-3662****Fayetteville, AR 72703-5077**Other **g.graves@courthouseconcepts.c****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

Lorena Keeling

2/16/2024

11:50 CST PM

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

Date (Mo/Day/Yr)

Time of Collection

**SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:**☐ UPS☐ FedEx☒ Quest Diagnostics Courier☐ 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

GABRIEL A RODAS LOPEZ

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

2/16/2024

Date (Mo/Day/Yr)

5/26/1984

(Mo/Day/Yr)

Email address: N/A

Daytime Phone No. 4793183933 Evening Phone No. 4793183933 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:☐ 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