**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:**

**03/20/2024 04:19 PM CDT UTC-5**

**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:**
**PRE-EMPLOYMENT**

**SPECIMEN ID:**
**QD26253522**

**COLLECTION DATE / TIME:**
**03/15/2024 02:12 PM EDT UTC-4**

**TESTING AUTHORITY:**
**DOT FMCSA**

**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 RESULT:**

**NEGATIVE**

**TEST LAB PANEL:**
**65304N**

**THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

**EMPLOYEE / APPLICANT:**
**PEREZ YAUNNER, JULIO**

**DONOR ID:**
**FLP625420653650**

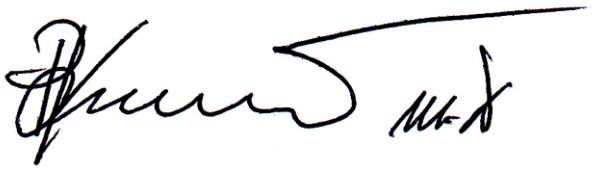
**NAME OF COMPANY / LOCATION:**
**ZIGI FREIGHT INC**
**6850 W 63RD STREET**
**CHICAGO IL 60638**

**LOCATION / COLLECTION SITE:**
**QUEST DIAGNOSTICS KENDALL DRI**
**11410 N KENDALL DRIVE**
**MIAMI FL 33176**
**PHONE: (305) 596-4576**

**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:**
**03/18/2024 11:46 AM CDT UTC-5**

**MRO COPY BECAME AVAILABLE AT:**
**03/18/2024 11:50 AM CDT UTC-5**

**DATE / TIME THE RESULT BECAME AVAILABLE:**
**03/18/2024 11:56 AM CDT UTC-5**

**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. **QD26253522**

Quest Diagnostics™ 800-877-7484

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
DER Name & Phone #: 6304857370 NIKOLA STAMENK
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.** FLP625420653650

**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:**

MP - Quest Diagnostics Kendall Drive - 54905
11410 N Kendall Dr Ste 107-109
Miami, FL 33176

**54905-MP**
Clinic ID

**Collector Contact Info: Phone** 305-274-5455
**Fax** 305-412-7325
**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:

**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

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

03 / 15 / 2024
Date (Mo./Day/Yr.)

2:12:17 ☐ AM ☑ PM
Time of Collection

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

**QUEST**
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 _____
Signature of Donor

JULIO PEREZ YAUNNER
(PRINT) Donor's Name (First, MI, Last)

03 / 15 / 2024
Date (Mo./Day/Yr.)

Email _____ Day Phone (786) 560-0612 Evening Phone (___) Not Provided Date of Birth 10 / 05 / 1965
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.)