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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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**06/29/2024 01:44 PM CDT UTC-5**

**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>CF17197739</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>06/27/2024 11:47 AM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>CDT 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:  
**NESSY RIVERO, JESUS ALFREDO**

DONOR ID:  
**FLN261421684030**

NAME OF COMPANY / LOCATION:  
**RIKI TRANSPORTATION INC**

**8225 LECLAIRE AVE**

**BURBANK IL 60459**

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:  
**06/28/2024 04:57 PM CDT UTC-5**

MRO COPY BECAME AVAILABLE AT:  
**06/27/2024 11:50 AM CDT UTC-5**

DATE / TIME THE RESULT BECAME AVAILABLE:  
**06/28/2024 04:58 PM CDT UTC-5**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 7 1 9 7 7 3 9

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 MRO@MED-STOP.COM	
C. Donor SSN, Employee I.D. No., or CDL State and No. <b>FL N261421684030</b>				
D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input checked="" type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG				
E. Reason for Test: <input checked="" type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____				
F. Drug Tests to be Performed: <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ <b>W215</b>				
G. Collection Site Address: <b>Med Stop - Hickory Hills</b> <b>7831 W 95th St Ste J</b> <b>Hickory Hills, IL 60457-2388</b>		Collection Site Code: <b>YMS.0003</b>	Collector Contact Info: Phone <b>(708)546-0551</b> Fax <b>(708)295-9162</b> Other <b>info@med-stop.com</b>	

OMB No. 0930-0158

**STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).**☒ URINE☐ ORAL FLUID

COLLECTION: <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.			
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark			
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided		Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

<b>X</b> Signature of Collector Dorota Moniuszko (PRINT) Collector's Name (First, MI, Last)	6/27/2024 Date (Mo/Day/Yr)	11:47 CDT PM Time of Collection	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
			<input type="checkbox"/> UPS <input type="checkbox"/> FedEx <input checked="" type="checkbox"/> Other CRL Courier 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.

<b>X</b> Signature of Donor Jesus A. Nessler (PRINT) Donor's Name (First, MI, Last)	6/27/2024 Date (Mo/Day/Yr)
Email address: N/A Daytime Phone No. 4078970762 Evening Phone No. 4078970762 Date of Birth 11/3/1968 (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:		
<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE for: _____ <input type="checkbox"/> DILUTE		
<input type="checkbox"/> REFUSAL TO TEST because - check reason(s) below: <input type="checkbox"/> TEST CANCELLED <input type="checkbox"/> ADULTERATED (adulterant/reason): _____ <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> OTHER: _____		
REMARKS:		
<b>X</b> _____ 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:

<input type="checkbox"/> RECONFIRMED for: _____ <input type="checkbox"/> FAILED TO RECONFIRM for: _____			<input type="checkbox"/> TEST CANCELLED
REMARKS:			
<b>X</b> _____ Signature of Medical Review Officer	_____ (PRINT) Medical Review Officer's Name (First, MI, Last)	____/____/____ Date (Mo/Day/Yr)	

COPY 2 - MEDICAL REVIEW OFFICER COPY