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:

08/16/2024 03:52 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:
7938830306

COLLECTION DATE / TIME:
08/15/2024 01:27 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:
LEGISTE, CLAUDIN

DONOR ID:
FLL223100912620

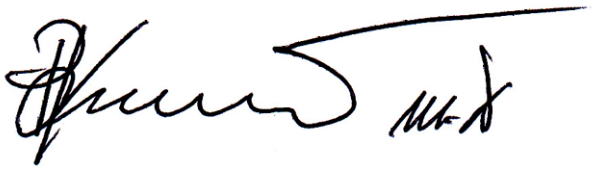
NAME OF COMPANY / LOCATION:
ZIGI FREIGHT INC
6850 W 63RD STREET
CHICAGO IL 60638

LOCATION / COLLECTION SITE:
CARESPOT - METRO WEST
2555 S KIRKMAN RD
ORLANDO FL 32811
PHONE: (407) 362-2030

LABORATORY PERFORMING TEST:
QUEST DIAGNOSTICS
10101 RENNER BLVD
LENEXA KS 66219
PHONE: (800) 877-7484

MEDICAL REVIEW OFFICER:
KWIECINSKI PAWEL K

SIGNATURE:



LAB RESULT RECEIVED AT:
08/16/2024 10:58 AM CDT UTC-5

MRO COPY BECAME AVAILABLE AT:
08/16/2024 11:00 AM CDT UTC-5

DATE / TIME THE RESULT BECAME AVAILABLE:
08/16/2024 11:17 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. 7938830306

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. FLL223100912620

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:
CareSpot - Metro West - 12959
2555 S KIRKMAN RD
ORLANDO, FL 32811

12959-FL552
Clinic ID

Collector Contact Info: Phone 407-362-2030
Fax 407-362-2040
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

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

08 / 15 / 2024
Date (Mo./Day/Yr.)

1:27:54 ☐ AM ☑ PM
Time of Collection

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 _____
Signature of Donor

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

08 / 15 / 2024
Date (Mo./Day/Yr.)

Email _____ Day Phone (630) 485-7370 Evening Phone (941) 600-8974 Date of Birth 07 / 22 / 1991
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.)