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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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**ZIGI FREIGHT INC**  
**6850 W 63RD STREET**  
**CHICAGO IL 60638**  
**PHONE: (630) 485-7370**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

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**NIKOLA STAMENKOVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**09/13/2024 09:45 AM 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>QD27008198</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>09/05/2024 12:13 PM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>EDT UTC-4</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:**  
**REEVES, WILLIS DEMETRIUS****DONOR ID:**  
**FLR120884772010****NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC**  
**6850 W 63RD STREET**  
**CHICAGO IL 60638****LOCATION / COLLECTION SITE:**  
**QUEST DIAGNOSTICS PALM BEACH**  
**9820 ALTERNATE A1A**  
**PALM BEACH GARDENS FL 33410**  
**PHONE: (772) 932-4989****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:**  
**09/07/2024 06:28 PM CDT UTC-5****MRO COPY BECAME AVAILABLE AT:**  
**09/07/2024 06:30 PM CDT UTC-5****DATE / TIME THE RESULT BECAME AVAILABLE:**  
**09/09/2024 08:17 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. QD27008198



OMB No. 0930-0158

## STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

Lab Acct #: 10624350

ZIGI FREIGHT INC  
6850 W 63RD STREET  
CHICAGO, IL 60638  
Phone: 630-485-7370 Fax: 630-485-6980

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.

FLR120884772010

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)

G. Collection Site Address:

AIMC - Quest Diagnostics Palm Beach Gardens - 56709  
9820 Alternate A1A Ste 206  
Palm Beach Gardens, FL 33410

56709-AIMC

Clinic ID

Collector Contact Info: Phone 772-932-4989

Fax 321-806-2278

Other

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

☒ URINE☐ ORAL FLUIDCollection: ☒ Split ☐ Single ☐ None Provided, Enter RemarkURINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark ☐ Observed, Enter RemarkORAL 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

Cassandra Edwards

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

Signature of Collector

09 / 05 / 2024

Date (Mo./Day/Yr.)

12:13:07

Time of Collection

☐ AM  
☒ PM

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

WILLIS D REEVES

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

09 / 05 / 2024

Date (Mo./Day/Yr.)

Email

Day Phone (813) 391-2223

Evening Phone (813) 391-2223

Date of Birth

06

/ 01 /

1977

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.)