



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:

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

ATTENTION TO:

RADOSLAV KOVACEVIC

SUBJECT:

URINE DRUG TESTING RESULTS

DOCUMENT CREATED AT:

09/23/2024 07:43 AM CDT UTC-5

PAGES:

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**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:	SPECIMEN ID:	MED-STOP MRO SERVICES
PRE-EMPLOYMENT	7936208271	9950 LAWRENCE AVE STE 403
COLLECTION DATE / TIME:	TESTING AUTHORITY:	SCHILLER PARK IL 60176
09/18/2024 11:06 AM	DOT FMCSA	PHONE: (877) 633-3633
EDT UTC-4		FAX: (847) 647-6608
TEST RESULT:		EMAIL: mro@med-stop.com

NEGATIVE

TEST LAB PANEL:

65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:

MICHAUD, JOHN W

DONOR ID:

FLM230479853730

NAME OF COMPANY / LOCATION:

RIKI TRANSPORTATION INC**8225 LECLAIRE AVE****BURBANK IL 60459**

LOCATION / COLLECTION SITE:

XPRESS URG CARE - LAUDERHILL**7229 W OAKLAND PARK BLVD****LAUDERHILL FL 33313****PHONE: (954) 824-2616**

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:

09/20/2024 02:27 PM CDT UTC-5

MRO COPY BECAME AVAILABLE AT:

09/20/2024 02:30 PM CDT UTC-5

DATE / TIME THE RESULT BECAME AVAILABLE:

09/20/2024 02:32 PM 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. 7936208271



OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. RIKI TRANSPORTATION INC 8225 LECLAIRE AVE BURBANK, IL 60459 Phone: 973-563-3159 Fax: 630-485-6980		Lab Acct #: 10783041 DER Name & Phone #: 7083035150 RADOSLAV KOVAC TESTING AUTHORITY FMCSA ACCOUNT NUMBER: 50180822235933	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. FLM230479853730			
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)			
G. Collection Site Address: Xpress Urg Care - Lauderdale - 55105 7229 W Oakland Park Blvd Ste 101 Lauderhill, FL 33313		Collector Contact Info: Phone 954-824-2616 Fax 754-667-4007 Other	

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

Collection: <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark	<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID
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.		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
X			
Antonio Cruz	Signature of Collector		
(PRINT) Collector's Name (First, MI, Last)	09 / 18 / 2024		
	Date (Mo./Day/Yr.)		
	11:06:32		
	Time of Collection		
	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		
	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		JOHN W MICHAUD	09 / 18 / 2024
	Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo./Day/Yr.)
Email	Day Phone (973) 563-3159	Evening Phone (786) 273-8653	Date of Birth 10 / 13 / 1985
			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

In accordance with applicable Federal requirements, my verification is:		<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID
<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:		
X		(PRINT) Medical Review Officer's Name (First, MI, Last)
	Signature of Medical Review Officer	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"/> TEST CANCELLED
<input type="checkbox"/> RECONFIRMED for:		
<input type="checkbox"/> FAILED TO RECONFIRM for:		
REMARKS:		
X		(PRINT) Medical Review Officer's Name (First, MI, Last)
	Signature of Medical Review Officer	Date (Mo./Day/Yr.)