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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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**10/14/2024 07:54 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>QD28574629</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>10/01/2024 12:53 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**

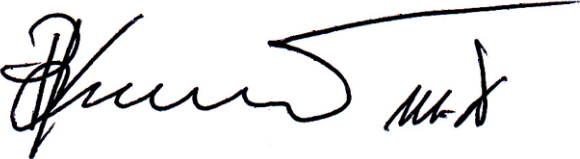
TEST LAB PANEL:

65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:	NAME OF COMPANY / LOCATION:
<b>ROVIROSA, RICARDO</b>	<b>ZIGI FREIGHT INC</b>
DONOR ID:	<b>6850 W 63RD STREET</b>
<b>FLR162720730070</b>	<b>CHICAGO IL 60638</b>

LOCATION / COLLECTION SITE:	LABORATORY PERFORMING TEST:
<b>QUEST DIAGNOSTICS KENDALL SQ</b>	<b>QUEST DIAGNOSTICS</b>
<b>12554 SW 120TH ST</b>	<b>10101 RENNER BLVD</b>
<b>MIAMI FL 33186</b>	<b>LENEXA KS 66219</b>
<b>PHONE: (305) 253-5008</b>	<b>PHONE: (800) 877-7484</b>

MEDICAL REVIEW OFFICER:	LAB RESULT RECEIVED AT:
<b>KWIECINSKI PAWEL K</b>	<b>10/03/2024 05:28 PM CDT UTC-5</b>
SIGNATURE:	MRO COPY BECAME AVAILABLE AT:
	<b>10/03/2024 05:30 PM CDT UTC-5</b>
	DATE / TIME THE RESULT BECAME AVAILABLE:
	<b>10/04/2024 07:38 AM CDT UTC-5</b>

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. QD28574629



OMB No. 0930-0158

## STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

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

Lab Acct #: 10624350

DER Name &amp; Phone #: 6304857370 NIKOLA STAMENK

TESTING AUTHORITY FMCSA

ACCOUNT NUMBER: 501512218129

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

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.

FLR162720730070

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:

IB2 - Quest Diagnostics Miami - 35404  
12554 SW 120TH ST  
MIAMI, FL 33186

35404-IB2

Clinic ID

Collector Contact Info: Phone 305-253-5009

Fax 302-253-5010

Other

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

☒ URINE☐ ORAL FLUIDCollection: ☒ 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

Zuzell Hernandez

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

10 / 01 / 2024

Date (Mo./Day/Yr.)

12:53:13

Time of Collection

☐ AM☒ PM

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

RICARDO ROVIROSA

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

10 / 01 / 2024

Date (Mo./Day/Yr.)

Email

Day Phone (786) 450-3791

Evening Phone (786) 450-3791

Date of Birth

01

/

07

/

1973

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.)