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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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**11/06/2024 11:12 AM CST UTC-6**

**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**

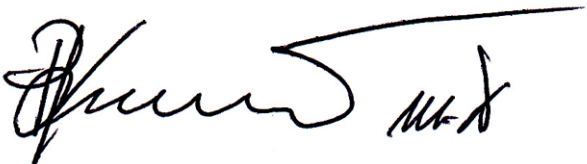
PURPOSE OF TEST:	SPECIMEN ID:	MED-STOP MRO SERVICES
<b>PRE-EMPLOYMENT</b>	<b>7939149304</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>10/28/2024 03:37 PM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>EST UTC-5</b>		<b>FAX: (847) 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:**  
**GARCIA MIRANDA, MAIKEL****DONOR ID:**  
**FLG625540822900****NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC****6850 W 63RD STREET**  
**CHICAGO IL 60638****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:****10/29/2024 05:08 PM CST UTC-6****MRO COPY BECAME AVAILABLE AT:****10/28/2024 02:40 PM CST UTC-6****DATE / TIME THE RESULT BECAME AVAILABLE:****10/30/2024 07:39 AM CST UTC-6**

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. **7939149304**

O M B No 0930-0158

## STEP 1 : COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

<b>A. Employer Name, Address, I.D. No.</b> ZIGI FREIGHT INC 6850 W 63RD STREET CHICAGO, IL 60638 Phone: 630-485-7370 Fax: 630-485-6980		<b>Lab Acct #:</b> 10624350 <b>DER Name &amp; Phone #:</b> 6304857370 NIKOLA STAMENK <b>TESTING AUTHORITY</b> FMCSA <b>ACCOUNT NUMBER:</b> 501512218129	<b>B. MRO Name, Address, Phone and Fax No.</b> PAWEL KWIECINSKI MD 9950 LAWRENCE AVE STE 403 SCHILLER PARK, IL 60176 Phone: 847-647-0453 Fax: 847-647-6608
<b>C. Donor SSN, Employee I.D., or CDL State and No.</b> FLG625540822900			
<b>D. Specify Testing Authority:</b> <input type="checkbox"/> HHS <input type="checkbox"/> NRC <input checked="" type="checkbox"/> 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			
<b>E. Reason for Test:</b> <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) _____			
<b>F. Drug Tests to be Performed:</b> <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (Specify) _____			
<b>G. Collection Site Address:</b> Xpress Urg Care - Lauderdale - 55105 7229 W Oakland Park Blvd Ste 101 Lauderhill, FL 33313		<b>Collector Contact Info:</b> Phone 954-824-2616 Fax 754-667-4007 Other _____	<b>Clinic ID</b> <b>55105-FL076</b>

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

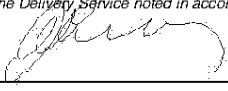
☒ URINE☐ ORAL FLUID

<b>Collection:</b> <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark _____
<b>URINE:</b> Collector reads urine temperature within 4 minutes. Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. Enter Remark _____ Observed, Enter Remark _____
<b>ORAL FLUID:</b> 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 Volume Indicator(s) Observed _____
<b>REMARKS:</b> _____

## 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  
Antonio Cruz  
10 / 28 / 2024  
3:37:43  
AM ☐ PM ☒

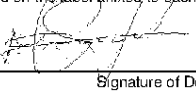
(PRINT) Collector's Name (First, MI, Last) Date (Mo./Day/Yr.) Time of Collection

## 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  
MAIKEL GARCIA-MIRANDA  
10 / 28 / 2024  
Date (Mo./Day/Yr.)

Email \_\_\_\_\_ Day Phone (630) 485-7370 Evening Phone (347) 372-5903 Date of Birth 08 / 10 / 1982  
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

<b>In accordance with applicable Federal requirements, my verification is:</b>	
<input type="checkbox"/> Negative <input type="checkbox"/> Positive for : _____	<input type="checkbox"/> TEST CANCELLED
<input type="checkbox"/> Dilute	
<input type="checkbox"/> Refusal to Test because - check reason(s) below: <input type="checkbox"/> ADULTERATED (adulterant/reason): _____ <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> OTHER: _____	
<b>REMARKS:</b> _____	
X 	
(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"/> TEST CANCELLED
<input type="checkbox"/> FAILED TO RECONFIRM for: _____	
<b>REMARKS:</b> _____	
X 	
(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)	