



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:

12/03/2024 02:55 PM CST UTC-6

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	7945258238	9950 LAWRENCE AVE STE 403
COLLECTION DATE / TIME:	TESTING AUTHORITY:	SCHILLER PARK IL 60176
11/27/2024 10:38 AM	DOT FMCSA	PHONE: (877) 633-3633
EST UTC-5		FAX: (847) 647-6608
TEST RESULT:		EMAIL: mro@med-stop.com

NEGATIVE

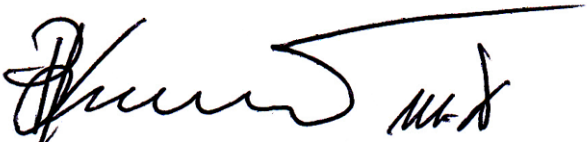
TEST LAB PANEL:

65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:	NAME OF COMPANY / LOCATION:
JOHNSON, GREGORY ALEXANDER	ZIGI FREIGHT INC
DONOR ID:	6850 W 63RD STREET
FLJ525281814020	CHICAGO IL 60638

LOCATION / COLLECTION SITE:	LABORATORY PERFORMING TEST:
AFC URGENT CARE - ALTAMONTE S	QUEST DIAGNOSTICS
1013 N SR 434	10101 RENNER BLVD
ALTAMONTE SPRINGS FL 32714	LENEXA KS 66219
PHONE: (407) 867-0008	PHONE: (800) 877-7484

MEDICAL REVIEW OFFICER:	LAB RESULT RECEIVED AT:
KWIECINSKI PAWEL K	11/29/2024 07:14 PM CST UTC-6
SIGNATURE:	MRO COPY BECAME AVAILABLE AT:
	11/27/2024 09:55 AM CST UTC-6
	DATE / TIME THE RESULT BECAME AVAILABLE:
	11/30/2024 08:13 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. **7945258238**

O M B 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. FLJ525281814020			
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: AFC Urgent Care - Altamonte Springs - 57584 1013 SR 434 Ste 1060 Altamonte Springs, FL 32714		Collector Contact Info: Phone 407-867-0008 Fax 408-477-5668 Other _____	Clinic ID 57584-FA008

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


☒ URINE☐ ORAL FLUID

Collection: <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark _____
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 _____ 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 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 

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

Signature of Collector
11 / 27 / 2024
Date (Mo./Day/Yr.)

10:38:00
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

GREGORY A JOHNSON
(PRINT) Donor's Name (First, MI, Last)

11 / 27 / 2024
Date (Mo./Day/Yr.)

Email _____ Day Phone (630) 485-7370 Evening Phone (585) 576-1099 Date of Birth 11 / 02 / 1981
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:	
<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: _____	
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:

<input type="checkbox"/> RECONFIRMED for: _____	<input type="checkbox"/> TEST CANCELLED
<input type="checkbox"/> FAILED TO RECONFIRM for: _____	
REMARKS: _____	
X _____ Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) _____ Date (Mo./Day/Yr.) _____	