



---

**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:**

---

**12/23/2024 08:03 AM CST UTC-6**

**PAGES:**

---

**2**

**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            |
| <b>PRE-EMPLOYMENT</b>      | <b>CF17203809</b>  | <b>9950 LAWRENCE AVE STE 403</b> |
| COLLECTION DATE / TIME:    | TESTING AUTHORITY: | <b>SCHILLER PARK IL 60176</b>    |
| <b>12/19/2024 01:04 PM</b> | <b>DOT FMCSA</b>   | <b>PHONE: (877) 633-3633</b>     |
| <b>CST UTC-6</b>           |                    | <b>FAX: (847) 647-6608</b>       |
| TEST RESULT:               |                    | <b>EMAIL: mro@med-stop.com</b>   |

**NEGATIVE**

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:

**LEFRID, YOUNESS**

DONOR ID:

**IA583AT6181**

NAME OF COMPANY / LOCATION:

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

LOCATION / COLLECTION SITE:

**MED-STOP HICKORY HILLS****7831 W 95TH ST****HICKORY HILLS IL 60457****PHONE: (708) 546-0551**

LABORATORY PERFORMING TEST:

**CLINICAL REFERENCE LABORATORY****8433 QUIVIRA****LENEXA KS 66215****PHONE: (800) 452-5677**

MEDICAL REVIEW OFFICER:

**KWIECINSKI PAWEL K**

SIGNATURE:



LAB RESULT RECEIVED AT:

**12/20/2024 11:51 AM CST UTC-6**

MRO COPY BECAME AVAILABLE AT:

**12/19/2024 01:10 PM CST UTC-6**

DATE / TIME THE RESULT BECAME AVAILABLE:

**12/20/2024 11:51 AM CST UTC-6**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 7 2 0 3 8 0 9

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

|   |  |                                       |  |  |
|---|--|---------------------------------------|--|--|
| A. Employer Name, Address, I.D. No.<br>KOVACEVIC RADOSLAV / RIKI TRANSPORTATION INC<br>8225 LECLAIRE AVE<br>BURBANK, IL 60459<br>Phone#: (973)563-3159 / Fax#: (630)485-6980  |  | Site Location                         | B. MRO Name, Address, Phone No. and Fax No.<br>PAWEL KWIECINSKI, MD (MRO4478)<br>MED-STOP INC<br>9950 LAWRENCE AVE SUITE 403<br>SCHILLER PARK, IL 60176<br>Phone#: (877)633-3633 / Fax#: (847)647-6608<br>MRO@MED-STOP.COM |  |
| C. Donor SSN, Employee I.D. No., or CDL State and No. <b>IA 583AT6181</b>   |  |                                       |  |  |
| 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) _____<br><b>W215</b>  |  |                                       |  |  |
| G. Collection Site Address: <b>Med Stop - Hickory Hills</b><br><b>7831 W 95th St Ste J</b><br><b>Hickory Hills, IL 60457-2388</b>   |  | Collection Site Code: <b>YMS.0003</b> | Collector Contact Info: Phone <b>(708)546-0551</b><br>Fax <b>(708)295-9162</b><br>Other <b>info@med-stop.com</b>   |  |

OMB No. 0930-0158

**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 <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.

|  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/><br>Signature of Collector                  | SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: |  |
|  | <input type="checkbox"/> UPS            | <input type="checkbox"/> FedEx   |
| Malgorzata Bodyziak<br>(PRINT) Collector's Name (First, MI, Last)              | 12/19/2024<br>Date (Mo/Day/Yr)          | 1:04 CST PM <input checked="" type="checkbox"/> AM<br>Time of Collection |
| Name of Delivery Service <input checked="" type="checkbox"/> Other CRL Courier |   |  |

**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/tube 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/tube is correct.

|   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/><br>Signature of Donor | YOUNESS LEFRID<br>(PRINT) Donor's Name (First, MI, Last) | 12/19/2024<br>Date (Mo/Day/Yr)                                       |
| Email address: younesslefrid1234@gmail.com                | Daytime Phone No. 3195389105                             | Evening Phone No. 3195389105 Date of Birth 12/25/1986<br>(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"/> 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: <input checked="" type="checkbox"/>                                   |   |
| Signature of Medical Review Officer  | (PRINT) Medical Review Officer's Name (First, MI, Last) |

**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: <input checked="" type="checkbox"/>            |   |
| Signature of Medical Review Officer                     | (PRINT) Medical Review Officer's Name (First, MI, Last) |

COPY 2 - MEDICAL REVIEW OFFICER COPY

# Query Detail

## Query Overview

Employer Conducting Query: RIKI TRANSPORTATION INC (USDOT# 3119062)

Query Result: Driver Not Prohibited

Query Status: Completed (12/19/2024 13:32:58)

Conducted By: Mateja Markovic | Query Type: Pre-employment | Query Submitted: Manually

### Driver Information

Name: YOUNESS LEFRID  
Date of Birth: 12/25/1986  
CDL/CLP ⓘ: US-IA-583AT6181

### Consent Information

Requested: 12/19/2024 13:31:50  
Recorded: 12/19/2024 13:32:58  
Status: Provided

### Query History

Created: 12/19/2024 13:31:50  
Completed: 12/19/2024 13:32:58  
Query Result: Driver Not Prohibited

## LEARN MORE

 The Return-to-Duty Process

## Open Violations

No Open Violations