



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:

01/08/2025 12:43 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

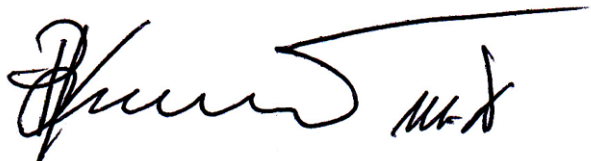
| | | |
|----------------------------|--------------------|----------------------------------|
| PURPOSE OF TEST: | SPECIMEN ID: | MED-STOP MRO SERVICES |
| PRE-EMPLOYMENT | CF20708514 | 9950 LAWRENCE AVE STE 403 |
| COLLECTION DATE / TIME: | TESTING AUTHORITY: | SCHILLER PARK IL 60176 |
| 01/02/2025 01:24 PM | DOT FMCSA | PHONE: (877) 633-3633 |
| EST UTC-5 | | FAX: (847) 647-6608 |
| TEST RESULT: | | EMAIL: mro@med-stop.com |

NEGATIVE

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
SAINT LOUIS, DJEFFSON**DONOR ID:**
FLS613248291000**NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC****6850 W 63RD STREET**
CHICAGO IL 60638**LOCATION / COLLECTION SITE:**
ASSOCIATES MD URGENT CARE - C
2122 W CYPRESS CREEK RD STE 11
FT LAUDERDALE FL 33309-1866
PHONE: (954) 353-3180**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:**
01/03/2025 01:20 PM CST UTC-6**MRO COPY BECAME AVAILABLE AT:**
01/02/2025 12:30 PM CST UTC-6**DATE / TIME THE RESULT BECAME AVAILABLE:**
01/03/2025 01:20 PM CST UTC-6

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





Marketplace

8433 Quivira Road
Lenexa, KS 66215

C F 2 0 7 0 8 5 1 4

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D2828543

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

| | | | | |
|---|--|---------------------------------------|--|--|
| A. Employer Name, Address, I.D. No. NIKOLA STAMENKOVIC / ZIGI FREIGHT INC 6850 W 63RD STREET CHICAGO, IL 60638 Phone#: (630)485-7370 / Fax#: (630)485-6980 | | Site Location | B. MRO Name, Address, Phone No. and Fax No. PAWEL KWIECINSKI, MD (MRO4478) MED-STOP INC 9950 LAWRENCE AVE SUITE 403 SCHILLER PARK, IL 60176 Phone#: (877)633-3633 / Fax#: (847)647-6608 MRO@MED-STOP.COM | |
| C. Donor SSN, Employee I.D. No., or CDL State and No. FLS613248291000 | | | | |
| 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) _____ W215 | | | | |
| G. Collection Site Address: Associates MD Urgent Care - 2122 W Cypress Creek Rd Ste Ft Lauderdale, FL 33309-1866 | | Collection Site Code: 7GS.2646 | Collector Contact Info: Phone (954)353-3180 Fax (954)353-3185 Other pinessurgentcare@associatesmd. | |

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"/> Signature of Collector Gloria Puerta (PRINT) Collector's Name (First, MI, Last) | | | Date (Mo/Day/Yr) 1/2/2025 Time of Collection 1:24 EST PM | | AM <input checked="" type="checkbox"/> |
| | | | SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: <input type="checkbox"/> UPS <input checked="" type="checkbox"/> FedEx <input type="checkbox"/> Other _____ 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/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"/> Signature of Donor DJEFFSON SAINT LOUIS (PRINT) Donor's Name (First, MI, Last) | Date (Mo/Day/Yr) 1/2/2025 Date (Mo/Day/Yr) 3/17/1996 |
| Email address: N/A | Daytime Phone No. 4078791398 Evening Phone No. 4078791398 Date of Birth |

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

COPY 2 - MEDICAL REVIEW OFFICER COPY

OMB No. 0930-0158