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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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**RIKI TRANSPORTATION INC**  
**8225 LECLAIRE AVE**  
**BURBANK IL 60459**  
**PHONE: (973) 563-3159**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

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**RADOSLAV KOVACEVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**01/13/2025 03:39 PM 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**

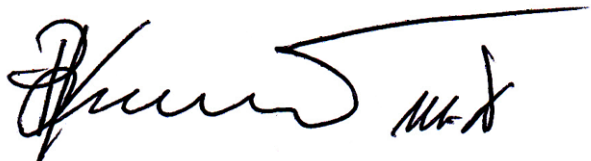
PURPOSE OF TEST:	SPECIMEN ID:	MED-STOP MRO SERVICES
<b>PRE-EMPLOYMENT</b>	<b>CF20708544</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>01/09/2025 11:39 AM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>EST UTC-5</b>		<b>FAX: (847) 647-6608</b>
TEST RESULT:		<b>EMAIL: mro@med-stop.com</b>

**NEGATIVE**

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

**EMPLOYEE / APPLICANT:**  
**MOORE, MARK ALEXANDER****DONOR ID:**  
**FLM600541882870****NAME OF COMPANY / LOCATION:**  
**RIKI TRANSPORTATION INC****8225 LECLAIRE AVE**  
**BURBANK IL 60459****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:**  
**01/13/2025 01:40 PM CST UTC-6****MRO COPY BECAME AVAILABLE AT:**  
**01/09/2025 10:45 AM CST UTC-6****DATE / TIME THE RESULT BECAME AVAILABLE:**  
**01/13/2025 01:55 PM CST UTC-6**

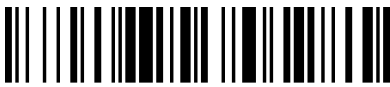
THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





Marketplace

8433 Quivira Road  
Lenexa, KS 66215

C F 2 0 7 0 8 5 4 4

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

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

ACCESSION NO.

<b>A. Employer Name, Address, I.D. No.</b> KOVACEVIC RADOSLAV / RIKI TRANSPORTATION INC 8225 LECLAIRE AVE BURBANK, IL 60459 Phone#: (973)563-3159 / Fax#: (630)485-6980		<b>Site Location</b>	<b>B. MRO Name, Address, Phone No. and Fax No.</b> 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	
<b>C. Donor SSN, Employee I.D. No., or CDL State and No.</b> <b>FLM600541882870</b>				
<b>D. Specify Testing Authority:</b> <input type="checkbox"/> HHS <input type="checkbox"/> NRC <b>Specify DOT Agency:</b> <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>W215</b>				
<b>G. Collection Site Address:</b> <b>Associates MD Urgent Care -</b> <b>2122 W Cypress Creek Rd Ste</b> <b>Ft Lauderdale, FL 33309-1866</b>		<b>Collection Site Code:</b> <b>7GS.2646</b>	<b>Collector Contact Info: Phone</b> <b>(954)353-3180</b> <b>Fax</b> <b>(954)353-3185</b> <b>Other</b> <b>pinessurgentcare@associatesmd.</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: Collector reads urine temperature within 4 minutes.</b> Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark			
<b>ORAL FLUID: Split Type:</b> <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided		<b>Each Device Within Expiration Date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

<b>X</b> Signature of Collector Gloria Puerta (PRINT) Collector's Name (First, MI, Last)	Date (Mo/Day/Yr) 1/9/2025 Time of Collection 11:39 EST PM AM <b>X</b>	<b>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</b> <input type="checkbox"/> UPS <input checked="" type="checkbox"/> FedEx <input type="checkbox"/> Other Name of Delivery Service
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**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.

<b>X</b> Signature of Donor MARK A MOORE (PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr) 1/9/2025 Date of Birth 8/7/1988 (Mo/Day/Yr)
Email address: m88moore@gmail.com Daytime Phone No. 7146616538 Evening Phone No. 7146616538	

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:		
<b>REMARKS:</b>		
<b>X</b> 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:
<b>REMARKS:</b>
<b>X</b> 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