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:

01/16/2025 12:19 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:
PRE-EMPLOYMENT

SPECIMEN ID:
CF20708558

COLLECTION DATE / TIME:
01/14/2025 01:22 PM EST UTC-5

TESTING AUTHORITY:
DOT FMCSA

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

TEST RESULT:

NEGATIVE

TEST LAB PANEL:
W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
GREENE, PAUL THOMAS JR

DONOR ID:
FLG650698862480

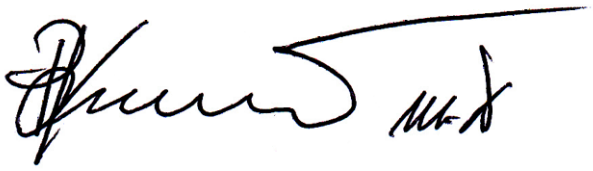
NAME OF COMPANY / LOCATION:
RIKI TRANSPORTATION INC
8225 LECLAIRE AVE
BURBANK IL 60459

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:
01/15/2025 03:30 PM CST UTC-6

MRO COPY BECAME AVAILABLE AT:
01/14/2025 12:25 PM CST UTC-6

DATE / TIME THE RESULT BECAME AVAILABLE:
01/15/2025 03:31 PM 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

CF20708558

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

CRL formfox Marketplace
8433 Quivira Road
Lenexa, KS 66215

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No.
KOVACEVIC RADOSLAV / RIKI TRANSPORTATION INC
8225 LECLAIRE AVE
BURBANK, IL 60459
Phone#: (973)563-3159 / 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. **FLG650698862480**

D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☒ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) ____

F. Drug Tests to be Performed: ☒ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ 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 **pinesurgentcare@associatesmd.**

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☒ **URINE** ☐ **ORAL FLUID**

COLLECTION: ☒ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100°F? ☒ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided | Each Device Within Expiration Date? ☐ Yes ☐ 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 _____ Signature of Collector

Leinor Feliz (PRINT) Collector's Name (First, MI, Last) | 1/14/2025 Date (Mo/Day/Yr) | 1:22 EST ☐ AM ☐ PM Time of Collection X

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
☐ UPS ☐ FedEx ☒ Other CRL Courier
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.

X _____ Signature of Donor

PAUL T GREENE (PRINT) Donor's Name (First, MI, Last)

1/14/2025 Date (Mo/Day/Yr)

Email address: paultgreene@yahoo.com Daytime Phone No. 9542249164 Evening Phone No. 7083035150 Date of Birth 7/8/1986 (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:

☐ NEGATIVE ☐ POSITIVE for: ____ ☐ DILUTE

☐ REFUSAL TO TEST because - check reason(s) below: ☐ TEST CANCELLED
☐ ADULTERATED (adulterant/reason): ____
☐ SUBSTITUTED
☐ 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:

☐ RECONFIRMED for: ____ ☐ TEST CANCELLED
☐ FAILED TO RECONFIRM for: ____

REMARKS: ____

X _____ Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo/Day/Yr)

COPY 2 - MEDICAL REVIEW OFFICER COPY