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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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**ZIGI FREIGHT INC**  
**6850 W 63RD STREET**  
**CHICAGO IL 60638**  
**PHONE: (630) 485-7370**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

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**NIKOLA STAMENKOVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**02/03/2025 11:07 AM 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>CF20708607</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>01/30/2025 04:28 PM</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:  
**RODRIGUEZ, EDDYCHEL**

DONOR ID:  
**FLR362200843760**

NAME OF COMPANY / LOCATION:

**ZIGI FREIGHT INC**

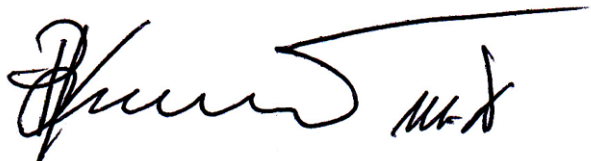
**6850 W 63RD STREET**  
**CHICAGO IL 60638**

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:  
**01/31/2025 02:42 PM CST UTC-6**

MRO COPY BECAME AVAILABLE AT:  
**01/30/2025 03:30 PM CST UTC-6**

DATE / TIME THE RESULT BECAME AVAILABLE:  
**01/31/2025 02:51 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 6 0 7

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. <b>FLR362200843760</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) _____ <b>W215</b>				
G. Collection Site Address: <b>Associates MD Urgent Care - 2122 W Cypress Creek Rd Ste Ft Lauderdale, FL 33309-1866</b>		Collection Site Code: <b>7GS.2646</b>	Collector Contact Info: Phone <b>(954)353-3180</b> Fax <b>(954)353-3185</b> Other <b>pinessurgentcare@associatesmd.</b>	

## 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.

X	 Signature of Collector Natalie Unanue (PRINT) Collector's Name (First, MI, Last)	1/30/2025 Date (Mo/Day/Yr)	4:28 EST PM X Time of Collection	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.

X	 Signature of Donor	EDDYCHEL RODRIGUEZ	1/30/2025
		(PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr)
Email address: N/A		Daytime Phone No. 3053156885	Evening Phone No. 6304857370
		Date of Birth	10/16/1984
			(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:		
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)

COPY 2 - MEDICAL REVIEW OFFICER COPY

OMB No. 0930-0158