



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:

04/01/2025 12:25 PM CDT UTC-5

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	QD27718656	9950 LAWRENCE AVE STE 403
COLLECTION DATE / TIME:	TESTING AUTHORITY:	SCHILLER PARK IL 60176
03/24/2025 01:23 PM	DOT FMCSA	PHONE: (877) 633-3633
EDT UTC-4		FAX: (847) 647-6608
TEST RESULT:		EMAIL: mro@med-stop.com

NEGATIVE

TEST LAB PANEL:

65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
BERNAL RAMIREZ, JULIO**DONOR ID:**
FLB241840834000**NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC**
6850 W 63RD STREET
CHICAGO IL 60638**LOCATION / COLLECTION SITE:**
QUEST DIAGNOSTICS MARGATE
5901 COLONIAL DR
MARGATE FL 33063
PHONE: (561) 302-3448**LABORATORY PERFORMING TEST:**
QUEST DIAGNOSTICS
10101 RENNER BLVD
LENEXA KS 66219
PHONE: (800) 877-7484**MEDICAL REVIEW OFFICER:**
KWIECINSKI PAWEL K**SIGNATURE:****LAB RESULT RECEIVED AT:**
03/26/2025 03:23 PM CDT UTC-5**MRO COPY BECAME AVAILABLE AT:**
03/24/2025 12:40 PM CDT UTC-5**DATE / TIME THE RESULT BECAME AVAILABLE:**
03/26/2025 03:28 PM CDT UTC-5

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE



SPECIMEN ID NO. **QD27718656****STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE****A. Employer Name, Address, I.D. No.**ZIGI FREIGHT INC
6850 W 63RD STREET
CHICAGO, IL 60638
Phone: 630-485-7370 Fax: 630-485-6980

Lab Acct #: 10624350

DER Name & Phone #: 6304857370 NIKOLA STAMENK
TESTING AUTHORITY FMCSA
ACCOUNT NUMBER: 501512218129**B. MRO Name, Address, Phone and Fax No.**PAWEL KWIECINSKI MD
9950 LAWRENCE AVE STE 403
SCHILLER PARK, IL 60176
Phone: 847-647-0453
Fax: 847-647-6608**C. Donor SSN, Employee I.D., or CDL State and No.**

FLB241840834000

D. Specify Testing Authority:☐ HHS☐ NRCSpecify 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)**G. Collection Site Address:**YQL - Quest Diagnostics Margate - 57580
5901 Colonial Dr Ste 106
Margate, FL 33063**57580-YQL**

Clinic ID

Collector Contact Info: Phone 561-302-3448**Fax** 954-970-9813**Other****STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).**☒ URINE☐ ORAL FLUIDCollection: ☒ 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

Juliana Cordeiro

03 / 24 / 2025

Date (Mo./Day/Yr.)

1:23:11

Time of Collection

☐ AM
☒ PM**SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:****QUEST**

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 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 is correct.

X

Signature of Donor

JULIO BERNALRAMIREZ

(PRINT) Donor's Name (First, MI, Last)

03 / 24 / 2025
Date (Mo./Day/Yr.)Email _____ Day Phone (630) 485-7370 Evening Phone (504) 205-0751 Date of Birth 02 / 20 / 1978
Date (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.)