MED STOP

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:

04/14/2025 10:17 AM 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**

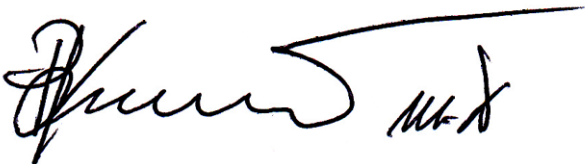12250409119174   PAGE 1 OF 2

RESULTS OF SAMSHA (NIDA) CONTROLLED TEST

PURPOSE OF TEST:

PRE-EMPLOYMENT

COLLECTION DATE / TIME:

**04/09/2025 11:00 AM
EDT UTC-4**

TEST RESULT:

SPECIMEN ID:

QD29629170

TESTING AUTHORITY:

DOT FMCSA

MED-STOP MRO SERVICES

9950 LAWRENCE AVE STE 403

SCHILLER PARK IL 60176

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FAX: (847) 647-6608

EMAIL: mro@med-stop.com

NEGATIVE

TEST LAB PANEL:

65304N

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:

SAINT JEAN, ANDERSON

DONOR ID:

MASA7401484

NAME OF COMPANY / LOCATION:

ZIGI FREIGHT INC

6850 W 63RD STREET

CHICAGO IL 60638

LOCATION / COLLECTION SITE:

QUEST DIAGNOSTICS FALL RIVER

101 PRESIDENT AVE, 1ST FLOOR

FALL RIVER MA 02720

PHONE: (508) 324-4105

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:

04/11/2025 06:11 PM CDT UTC-5

MRO COPY BECAME AVAILABLE AT:

04/09/2025 10:21 AM CDT UTC-5

DATE / TIME THE RESULT BECAME AVAILABLE:

04/12/2025 08:37 AM CDT UTC-5

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE

Quest Diagnostics™
800-877-7484

SPECIMEN ID NO. **QD29629170**

STEP 1 : COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.		B. MRO Name, Address, Phone and Fax 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	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. MASA7401484

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)

G. Collection Site Address:

YOB - Quest Diagnostics Fall River - 29536
101 President Ave, 1st Floor
Fall River, MA 02720

29536-YOB
Clinic ID

Collector Contact Info: Phone 508-324-4105
Fax 508-646-3645
Other

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: 10:00 qns drinking water

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.

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

X _____

JENNIFER PASCHOAL	04 / 09 / 2025	11:00:51	✓ AM ☐ PM	QUEST
(PRINT) Collector's Name (First, MI, Last)	Date (Mo./Day/Yr.)	Time of Collection		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 _____   ANDERSON SAINT JEAN   04 / 09 / 2025

Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo./Day/Yr.)

Email _____ Day Phone (630) 485-7370 Evening Phone (774) 206-7353 Date of Birth 01 / 29 / 1995
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.)