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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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**05/09/2025 08:56 AM CDT UTC-5**

**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**

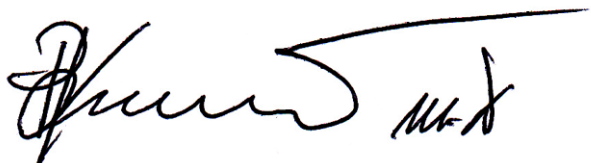
PURPOSE OF TEST:	SPECIMEN ID:	MED-STOP MRO SERVICES
<b>PRE-EMPLOYMENT</b>	<b>CF20366904</b>	<b>9950 LAWRENCE AVE STE 403</b>
COLLECTION DATE / TIME:	TESTING AUTHORITY:	<b>SCHILLER PARK IL 60176</b>
<b>05/06/2025 01:38 PM</b>	<b>DOT FMCSA</b>	<b>PHONE: (877) 633-3633</b>
<b>EDT UTC-4</b>		<b>FAX: (847) 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:**  
**ESCALONA, REINALDO****DONOR ID:**  
**FLE245720690060****NAME OF COMPANY / LOCATION:****ZIGI FREIGHT INC**  
**6850 W 63RD STREET**  
**CHICAGO IL 60638****LOCATION / COLLECTION SITE:**  
**NETC HEALTH LAB SERVICES, LLC**  
**401 N MILLS AVE STE B**  
**ORLANDO FL 32803-5735**  
**PHONE: (407) 734-2546****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:**  
**05/07/2025 03:57 PM CDT UTC-5****MRO COPY BECAME AVAILABLE AT:**  
**05/06/2025 12:40 PM CDT UTC-5****DATE / TIME THE RESULT BECAME AVAILABLE:**  
**05/07/2025 04:01 PM CDT UTC-5**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





Marketplace

8433 Quivira Road  
Lenexa, KS 66215

CF20366904

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 ST 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>FLE245720690060</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>NetC Health Lab Services, LLC</b> <b>401 N Mills Ave Ste B</b> <b>Orlando, FL 32803-5735</b>		Collection Site Code: <b>7GS.4620</b>	Collector Contact Info: Phone <b>(407)734-2546</b> Fax <b>(407)734-2527</b> Other <b>fmeyers@netchealthlabservices</b>	

OMB No. 0930-0158

**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.

<input checked="" type="checkbox"/> Signature of Collector Yamilet c Cruz (PRINT) Collector's Name (First, MI, Last)	Date (Mo/Day/Yr) 5/6/2025 Time of Collection 1:38 EDT PM <input checked="" type="checkbox"/> AM	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.

<input checked="" type="checkbox"/> Signature of Donor Email address: N/A	REINALDO ESCALONA (PRINT) Donor's Name (First, MI, Last)	5/6/2025 Date (Mo/Day/Yr)
Daytime Phone No. 4077584705	Evening Phone No. 6304857370	1/6/1969 Date of Birth (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"/> ADULTERATED (adulterant/reason): _____ <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> OTHER: _____		<input type="checkbox"/> TEST CANCELLED
REMARKS:		
<input checked="" type="checkbox"/> 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"/> FAILED TO RECONFIRM for: _____	<input type="checkbox"/> TEST CANCELLED
REMARKS:	
<input checked="" type="checkbox"/> Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)
/ / Date (Mo/Day/Yr)	

COPY 2 - MEDICAL REVIEW OFFICER COPY