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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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**RIKI TRANSPORTATION INC**  
**8225 LECLAIRE AVE**  
**BURBANK IL 60459**  
**PHONE: (973) 563-3159**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

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**RADOSLAV KOVACEVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**05/28/2025 03:18 PM 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>CF20612874</b>  | <b>9950 LAWRENCE AVE STE 403</b> |
| COLLECTION DATE / TIME:    | TESTING AUTHORITY: | <b>SCHILLER PARK IL 60176</b>    |
| <b>05/27/2025 04:53 PM</b> | <b>DOT FMCSA</b>   | <b>PHONE: (877) 633-3633</b>     |
| <b>CDT 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:

**PRIDE, JOHN**

DONOR ID:

**TN080051280**

NAME OF COMPANY / LOCATION:

**RIKI TRANSPORTATION INC****8225 LECLAIRE AVE****BURBANK IL 60459**

LOCATION / COLLECTION SITE:

**MED-STOP HICKORY HILLS****7831 W 95TH ST****HICKORY HILLS IL 60457****PHONE: (708) 546-0551**

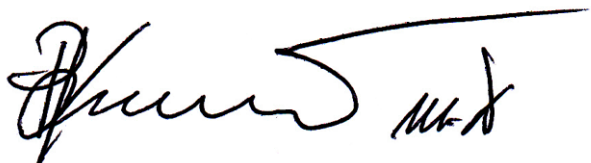
LABORATORY PERFORMING TEST:

**CLINICAL REFERENCE LABORATORY****8433 QUIVIRA****LENEXA KS 66215****PHONE: (800) 452-5677**

MEDICAL REVIEW OFFICER:

**KWIECINSKI PAUL**

SIGNATURE:



LAB RESULT RECEIVED AT:

**05/28/2025 12:27 PM CDT UTC-5**

MRO COPY BECAME AVAILABLE AT:

**05/27/2025 05:00 PM CDT UTC-5**

DATE / TIME THE RESULT BECAME AVAILABLE:

**05/28/2025 12:36 PM CDT UTC-5**

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





CF20612874

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

|  |  |   |  |  |
|--|--|---|--|--|
| <b>A. Employer Name, Address, I.D. No.</b><br>KOVACEVIC RADOSLAV / RIKI TRANSPORTATION INC<br>8225 LECLAIRE AVE<br>BURBANK, IL 60459<br>Phone#: (973)563-3159 / Fax#: (630)485-6980  |  | <b>Site Location</b>                            | <b>B. MRO Name, Address, Phone No. and Fax No.</b><br>PAUL KWIECINSKI, MD (MRO4478)<br>MED-STOP INC<br>9950 LAWRENCE AVE SUITE 403<br>SCHILLER PARK, IL 60176<br>Phone#: (877)633-3633 / Fax#: (847)647-6608<br>MRO@MED-STOP.COM |  |
| <b>C. Donor SSN, Employee I.D. No., or CDL State and No.</b> <b>TN 080051280</b>   |  |   |  |  |
| <b>D. Specify Testing Authority:</b> <input type="checkbox"/> HHS <input type="checkbox"/> NRC <b>Specify DOT Agency:</b> <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      |  |   |  |  |
| <b>E. Reason for Test:</b> <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) |  |   |  |  |
| <b>F. Drug Tests to be Performed:</b> <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify)   |  |   |  |  |
| <b>W215</b>  |  |   |  |  |
| <b>G. Collection Site Address:</b> <b>Med Stop - Hickory Hills</b><br><b>7831 W 95th St Ste J</b><br><b>Hickory Hills, IL 60457-2388</b>   |  | <b>Collection Site Code:</b><br><b>YMS.0003</b> | <b>Collector Contact Info:</b> Phone <b>(708)546-0551</b><br>Fax <b>(708)295-9162</b><br>Other <b>info@med-stop.com</b>  |  |

OMB No. 0930-0158

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

|  |  |   |  |
|--|--|---|--|
| <b>COLLECTION:</b> <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.   |  |   |  |
| <b>URINE: Collector reads urine temperature within 4 minutes.</b> Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark |  |   |  |
| <b>ORAL FLUID: Split Type:</b> <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided   |  | <b>Each Device Within Expiration Date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed |  |
| <b>REMARKS:</b>  |  |   |  |

**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.

|   |  |  |  |
|---|--|--|--|
| <b>X</b>  |  | <b>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</b><br><input type="checkbox"/> UPS <input type="checkbox"/> FedEx <input checked="" type="checkbox"/> Other <b>CRL Courier</b> |  |
| Signature of Collector<br><b>Agnieszka a Horodowicz</b><br>(PRINT) Collector's Name (First, MI, Last) |  | Date (Mo/Day/Yr) <b>5/27/2025</b><br>Time of Collection <b>4:53 CDT PM X</b>   |  |

**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.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| <b>X</b>                                  |  | <b>JOHN PRIDE</b><br>(PRINT) Donor's Name (First, MI, Last) |  | <b>5/27/2025</b><br>Date (Mo/Day/Yr)         |  |
| Email address: <b>jpride615@gmail.com</b> |  | Daytime Phone No. <b>6152406370</b>                         |  | Evening Phone No. <b>6152406370</b>          |  |
|   |  |   |  | <b>3/4/1978</b><br>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:<br><input type="checkbox"/> <b>NEGATIVE</b> <input type="checkbox"/> <b>POSITIVE</b> for: _____<br><input type="checkbox"/> <b>DILUTE</b>   |  |  |
| <input type="checkbox"/> <b>REFUSAL TO TEST</b> because - check reason(s) below:<br><input type="checkbox"/> <b>ADULTERATED</b> (adulterant/reason): _____<br><input type="checkbox"/> <b>SUBSTITUTED</b><br><input type="checkbox"/> <b>OTHER:</b> _____ |  | <input type="checkbox"/> <b>TEST CANCELLED</b>   |
| <b>REMARKS:</b>   |  |  |
| <b>X</b>  |  | (PRINT) Medical Review Officer's Name (First, MI, Last) _____<br>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"/> <b>RECONFIRMED</b> for: _____         |  | <input type="checkbox"/> <b>TEST CANCELLED</b>   |
| <input type="checkbox"/> <b>FAILED TO RECONFIRM</b> for: _____ |  |  |
| <b>REMARKS:</b>  |  |  |
| <b>X</b>   |  | (PRINT) Medical Review Officer's Name (First, MI, Last) _____<br>Date (Mo/Day/Yr) ____/____/____ |

COPY 2 - MEDICAL REVIEW OFFICER COPY

# Query Detail

## Query Overview

Employer Conducting Query: RIKI TRANSPORTATION INC (USDOT# 3119062)

Query Result: Driver Not Prohibited

Query Status: Completed (5/27/2025 17:16:29)

Conducted By: Mateja Markovic | Query Type: Pre-employment | Query Submitted: Manually

### Driver Information

Name: JOHN PRIDE  
Date of Birth: 3/4/1978  
CDL/CLP ⓘ: US-TN-080051280

### Consent Information

Requested: 5/27/2025 17:12:27  
Recorded: 5/27/2025 17:16:29  
Status: Provided

### Query History

Created: 5/27/2025 17:12:27  
Completed: 5/27/2025 17:16:29  
Query Result: Driver Not Prohibited

## Open Violations

No Open Violations