



MED-STOP MRO SERVICES
7042 N MILWAUKEE AVE
NILES IL 60714
PHONE: (877) 633-3633
FAX: (847) 647-6608
mro@med-stop.com

MRO RESULT

TO:

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

ATTENTION TO:

RADOSLAV KOVACEVIC

SUBJECT:

URINE DRUG TESTING RESULTS

DOCUMENT CREATED AT:

12/12/2022 3:54 PM

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	CF08739781	7042 N MILWAUKEE AVE
COLLECTION DATE / TIME:	TESTING AUTHORITY:	NILES IL 60714
7/20/2022 1:38 PM	DOT FMCSA	PHONE: (877) 633-3633
TEST RESULT:		FAX: (847) 647-6608
		mro@med-stop.com

NEGATIVE

TEST LAB PANEL:
W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
ALVAREZ CERVANTES, ALFONSO SAUL

NAME OF COMPANY / LOCATION:
RIKI TRANSPORTATION INC

DONOR ID:
FLA416017733730

8225 LECLAIRE AVE
BURBANK IL 60459

BIRTH DATE:
10/13/1973

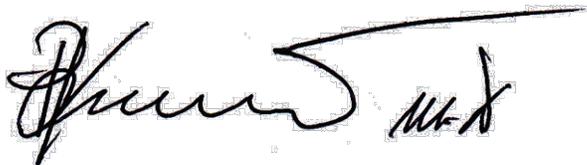
LOCATION / COLLECTION SITE:
MED-STOP HICKORY HILLS
7831 W 95TH ST
HICKORY HILLS IL 60457
PHONE: (708) 546-0551

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

MEDICAL REVIEW OFFICER:
KWIECINSKI PAWEL K

LAB RESULT RECEIVED AT:
7/21/2022 11:11 AM

SIGNATURE:



MRO COPY BECAME AVAILABLE AT:
7/20/2022 1:42 PM

DATE / TIME THE RESULT BECAME AVAILABLE:
7/21/2022 11:11 AM

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 0 8 7 3 9 7 8 1

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. KOVACEVIC RADOSLAV RIKI TRANSPORTATION INC 8225 LECLAIRE AVE BURBANK, IL 60459 Phone#: (973)563-3159 / Fax#: (630)485-6980		Site Location FL A416017733730	B. MRO Name, Address, Phone No. and Fax No. PAWEL KWIECINSKI, MD (MRO4478) MED-STOP INC 7042 N MILWAUKEE AVE NILES, IL 60714 Phone#: (877)633-3633 / Fax#: (847)647-6608	
C. Donor SSN, Employee I.D. No., or CDL State and No.				
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) _____ W215				
G. Collection Site Address: Med Stop - Hickory Hills 7831 W 95th St Hickory Hills, IL 60457-2387		Collection Site Code: YMS.0003	Collector Contact Info: Phone (708)546-0551 Fax (708)295-9162 Other info@med-stop.com	

OMB No. 0930-0158

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:

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		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
	Dorota Moniuszko	7/20/2022	1:38 CDT	<input checked="" type="checkbox"/> Other CRL Courier
(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/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"/>	ALFONSO S ALVAREZ CERVANTES	7/20/2022
Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr)
Email address <u>alvarezsaul444@gmail.com</u>	Daytime Phone No. <u>2392000223</u>	Evening Phone No. <u>2392000223</u>
	Date of Birth <u>10/13/1973</u>	(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:

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:

Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/Day/Yr)