



MED-STOP MRO SERVICES
7042 N MILWAUKEE AVE
NILES IL 60714
PHONE: (877) 633-3633
FAX: (847) 647-6608

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:

7/13/2022 2:56 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	CF08743156	7042 N MILWAUKEE AVE
COLLECTION DATE / TIME:	TESTING AUTHORITY:	NILES IL 60714
7/5/2022 4:19 PM	DOT FMCSA	PHONE: (877) 633-3633
		FAX: (847) 647-6608

TEST RESULT:

NEGATIVE

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:
**GARCIA ALVAREZ, CARLOS
RAFAEL**

SOCIAL SECURITY NUMBER:
597-34-2030

BIRTH DATE:
12/4/1991

NAME OF COMPANY / LOCATION:
RIKI TRANSPORTATION INC

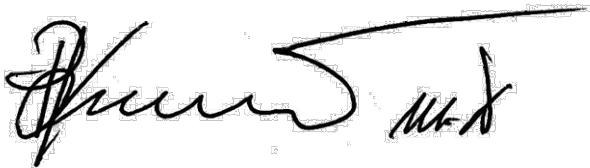
**8225 LECLAIRE AVE
BURBANK IL 60459**

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 PAWEL K

SIGNATURE:



LAB RESULT RECEIVED AT:
7/6/2022 11:22 AM

MRO COPY BECAME AVAILABLE AT:
7/5/2022 4:22 PM

DATE / TIME THE RESULT BECAME AVAILABLE:
7/6/2022 11:25 AM

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE



MED-STOP

SERVICE AGREEMENT AND RECEIPT

CUSTOMER NAME

**GARCIA ALVAREZ, CARLOS
RAFAEL**

CUSTOMER MED-STOP CODE

40200331386394

CUSTOMER ADDRESS

**31 ALLEN ST WEST PALM
BEACH FL 33404**

SERVICE LOCATION

**MED-STOP HICKORY HILLS
7831 W 95TH ST
HICKORY HILLS IL 60457**

TRANSACTION CODE

60220705125937

TRANSACTION DATE AND TIME

7/5/2022 4:13 PM

SERVICE DATE AND TIME

7/5/2022 4:13 PM

SERVICES PERFORMED

DRUG TEST - PRE-EMPLOYMENT

AMOUNT

\$80.00

TRANSACTION TYPE: PRE-PAID BY EMPLOYER RIKI TRANSPORTATION INC PROCESSED ON: 7/5/2022 4:13:35 PM

TOTAL

\$80.00

Med-Stop Service Agreement

This Med-Stop Service agreement is made and effective on 7/5/2022 date between GARCIA ALVAREZ, CARLOS RAFAEL with the main address at 31 ALLEN ST WEST PALM BEACH FL 33404 and Med-Stop with the main office located at 7042 N. MILWAUKEE AVE. NILES, ILLINOIS 60714.

1. Service consent

I GARCIA ALVAREZ, CARLOS RAFAEL, consent to the Med-Stop service provided to me and understand that the service is performed for the purpose of creating protected health information to determine my fitness to perform the safety-sensitive functions as required by the federal regulations under 49 CFR part 382, and 40, or as specified by my current or prospective employer. I will not hold Med-Stop, its employees or contractors responsible for any errors or omissions that I may have made during the service. I understand that the Med-Stop service provided must strictly adhere to applicable laws, rules, and regulations.

2. Financial charges

I GARCIA ALVAREZ, CARLOS RAFAEL understand that all charges are due at the time of the service. I agree to pay all Med-Stop charges for the service provided to me by the Med-Stop collectors or medical examiners. The charge for the service is nonrefundable.

3. Confidentiality and release of information

I GARCIA ALVAREZ, CARLOS RAFAEL understand that my personal information and service records may be disclosed or used only as permitted by applicable laws and regulations. Med-Stop is not permitted to disclose my service records to third parties without written consent unless allowed or required by law. A "third party" is any person or organization to whom specific regulations do not explicitly authorize or require the transmission of information in the course of the service process. I understand that my service records may be released (without your consent) in certain situations, such as legal proceedings, grievances, or administrative proceedings brought by you or on your behalf which resulted from a positive drug or alcohol test or refusal to submit to a drug or alcohol test.

4. Personal valuables

Med-Stop shall not be liable for the loss of or damage to any money, documents, or other personal property that may occur during the visit to the Med-Stop Test Centers.

For Additional Services visit us on the Internet

<https://med-stop.com>

Using Med-Stop you can:

- Fax your test results to selected employer
- Keep track of all important dates especially your Medical Examination Expiration date
- Request reprints - duplicates of your recent Medical Examiner's Certificate
- Update your address and contact information

Accessing Med-Stop is easy:

- Open our web site: <https://med-stop.com>
- Click the "Sign In" button located in the top right corner
- On the secured Login Page type your Med-Stop User Name.

Your initial Med-Stop User Name is:

40200331386394

Your initial Password is:

I hereby enter into this agreement with Med-Stop, certify that I have read and agree to the foregoing. I understand that I will get a copy of this agreement after I sign it.



Customer signature



C F 0 8 7 4 3 1 5 6

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D3119062

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

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 G624116914440	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) _____			
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

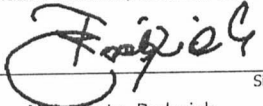
STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

☒ 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.		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: <input type="checkbox"/> UPS <input type="checkbox"/> FedEx <input checked="" type="checkbox"/> Other CRL Courier	
<input checked="" type="checkbox"/>  Signature of Collector	7/5/2022 Date (Mo/Day/Yr)	4:19 CDT PM <input checked="" type="checkbox"/> Time of Collection	Name of Delivery Service
(PRINT) Collector's Name (First, MI, Last) Małgorzata Bodyziak			


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.		CARLOS R GARCIA ALVAREZ (PRINT) Donor's Name (First, MI, Last)		7/5/2022 Date (Mo/Day/Yr)
<input checked="" type="checkbox"/>  Signature of Donor	onechoicercargoinc91@gmail.com Email address:	5615671364 Daytime Phone No.	5615671364 Evening Phone No.	12/4/1991 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"/> TEST CANCELLED
<input type="checkbox"/> ADULTERATED (adulterant/reason): _____		
<input type="checkbox"/> SUBSTITUTED		
<input type="checkbox"/> OTHER: _____		
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"/> TEST CANCELLED
<input type="checkbox"/> FAILED TO RECONFIRM for: _____		
REMARKS:		
<input checked="" type="checkbox"/>  Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)

COPY 5 - DONOR COPY

Test Notification

Med-Stop Code: 52220705123560

Expires on 07/08/2022 03:20 PM CST

49 CFR 382.113 REQUIREMENT FOR NOTICE

Before performing each alcohol or controlled substances test under this part, each employer shall notify a driver that the alcohol or controlled substances test is required by this part. No employer shall falsely represent that a test is administered under this part.

Company Name **RIKI TRANSPORTATION INC**
Company Address **8225 LECLAIRE AVE BURBANK IL 60459**
Company Phone **(973) 563-3159** Company DER **KOVACEVIC, RADOSLAV**
Donor Name **GARCIA ALVAREZ, CARLOS**
Donor Phone **(561) 567-1364** Donor ID **FLG624116914440**

You are hereby notified the following test will be administered in compliance with the Federal Motor Carrier Safety Regulations
Please bring this confirmation and your driver's license or other government issued photo ID to the collection site for identification.

Laboratory **PHONE: FAX:**
Company Account _____ Med-Stop Code **52220705123560**
Not Later than **07/05/2022 03:20 PM CDT UTC-5**
Test Type **DRUG TEST DOT REGULATED FMCSA W215**
Reason for Test **PRE-EMPLOYMENT**
Collection Site **MED-STOP HICKORY HILLS**
Collection Site Address **7831 W 95TH ST HICKORY HILLS IL 60457**
Collection Site Phone **(708) 546-0551** Collection Site Fax Number **(708) 295-9162**
Collection Site Work Hours **8:00am - 1:00pm 8:00am - 4:00pm 1:00pm - 7:00pm**
Test Payment Form **EMPLOYER**
Test Instructions _____
Medical Review Officer **PHONE: FAX:**

I understand as a condition of my employment with this company, the above identified test is required.

Donor Signature _____

Date _____

Designated Employer Representative Signature _____

Date _____

COMPLIANCE REQUIREMENTS

Selected person must report for drug and/or alcohol testing IMMEDIATELY after receipt of this document. Personnel who do not comply in a timely manner will be listed as Refusal to Test. Please bring your government issued Photo Id for identification at the Collection Facility.

You must provide the Collector with the Med-Stop Code: 52220705123560