



MED-STOP MRO SERVICES
9950 LAWRENCE AVE STE 403
SCHILLER PARK IL 60176
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:

9/28/2023 11:23 AM

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:

RANDOM

SPECIMEN ID:

7903150804

COLLECTION DATE / TIME:

9/6/2023 5:12 PM

TESTING AUTHORITY:

DOT FMCSA**MED-STOP MRO SERVICES****9950 LAWRENCE AVE STE 403****SCHILLER PARK IL 60176****PHONE: (877) 633-3633****FAX: (847) 647-6608****mro@med-stop.com**

TEST RESULT:

NEGATIVE

TEST LAB PANEL:

65304N**THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

EMPLOYEE / APPLICANT:

NAVARRETE, JOSEPH NICHOLAS

DONOR ID:

FLN163494793900

NAME OF COMPANY / LOCATION:

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

LOCATION / COLLECTION SITE:

BAPTIST MEMORIAL HOSPITAL**100 HOSPITAL ST****BOONEVILLE MS 38829****PHONE: (662) 720-5096**

LABORATORY PERFORMING TEST:

QUEST DIAGNOSTICS**10101 RENNER BLVD****LENEXA KS 66219****PHONE: (866) 697-8378**

MEDICAL REVIEW OFFICER:

KWIECINSKI PAWEL K

SIGNATURE:



LAB RESULT RECEIVED AT:

9/8/2023 8:07 PM

MRO COPY BECAME AVAILABLE AT:

9/8/2023 8:10 PM

DATE / TIME THE RESULT BECAME AVAILABLE:

9/9/2023 9:21 AM**THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 7903150804



O M B No. 0930-0158

STEP 1 : COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

RIKI TRANSPORTATION INC
8225 LECLAIRE AVE
BURBANK, IL 60459
Phone: 973-563-3159 Fax: 630-485-6980

Lab Acct #: 10783041

TESTING AUTHORITY FMCSA
ACCOUNT NUMBER: 50180822235933

B. MRO Name, Address, Phone and Fax No.

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. FLN163494793900

D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCGE. 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:

BMHCC - Booneville - 11302
100 HOSPITAL ST
BOONEVILLE, MS 38829

11302-MS662

Clinic ID

Collector Contact Info: Phone 662-720-5096

Fax 662-720-5041

Other

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

☒ URINE☐ ORAL FLUIDCollection: ☒ Split ☐ Single ☐ None Provided, Enter RemarkURINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? ☒ Yes ☐ No. Enter Remark ☐ Observed, Enter RemarkORAL FLUID: Split type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS: DER Name: DER

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.

X

Signature of Collector

Samantha Howell

09 / 06 / 2023

5:12:36

☐ AM
☒ PM

(PRINT) Collector's Name (First, MI, Last)

Date (Mo./Day/Yr.)

Time of Collection

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

FEDEX

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

Signature of Donor

JOSEPH N NAVARRETE

(PRINT) Donor's Name (First, MI, Last)

09 / 06 / 2023

Date (Mo./Day/Yr.)

Email _____ Day Phone (305) 303-7088 Evening Phone () Not Provided Date of Birth 10 / 30 / 1979

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.)