



## SERVICE AGREEMENT AND RECEIPT

CUSTOMER NAME

GRIFFIE, DERRICK JEREMY

SERVICE LOCATION

MED-STOP HICKORY HILLS

TRANSACTION CODE

60230125659107

CUSTOMER MED-STOP CODE

40230125657220

7831 W 95TH ST

HICKORY HILLS IL 60457

TRANSACTION DATE AND TIME

1/25/2023 11:39 AM

CUSTOMER ADDRESS

5381 TOPEKA CT DENVER CO  
80239

SERVICE DATE AND TIME

1/25/2023 11:39 AM

SERVICES PERFORMED

AMOUNT

**DRUG TEST - PRE-EMPLOYMENT****\$90.00**

TRANSACTION TYPE: PRE-PAID BY EMPLOYER RIKI TRANSPORTATION INC PROCESSED ON: 1/25/2023 11:39:38 AM

**TOTAL****\$90.00****Med-Stop Service Agreement**

This Med-Stop Service agreement is made and effective on 1/25/2023 date between GRIFFIE, DERRICK JEREMY with the main address at 5381 TOPEKA CT DENVER CO 80239 and Med-Stop with the main office located at 7042 N. MILWAUKEE AVE. NILES, ILLINOIS 60714.

**1. Service consent**

I GRIFFIE, DERRICK JEREMY, 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 GRIFFIE, DERRICK JEREMY 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 GRIFFIE, DERRICK JEREMY 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:**

40230125657220

**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 1 1 8 9 8 0 6 6

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	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.		CO 021780541		
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: <u>Med Stop - Hickory Hills</u> <u>7831 W 95th St Ste J</u> <u>Hickory Hills, IL 60457-2388</u>		Collection Site Code: <b>YMS.0003</b>	Collector Contact Info: Phone <b>(708)546-0551</b> Fax <b>(708)295-9162</b> Other <b>info@med-stop.com</b>	

## 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"/>	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
	<input type="checkbox"/> UPS	<input type="checkbox"/> FedEx
Signature of Collector	<input checked="" type="checkbox"/> Other CRL Courier	
Malgorzata Bodyziak	1/25/2023	11:44 CST PM
(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"/>	DERRICK J GRIFFIE	1/25/2023
Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr)
Email address: N/A	Daytime Phone No. 7207429430	Evening Phone No. 7207429430
	Date of Birth	5/28/1986
		(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

OMB No. 0930-0158



# Test Notification



Expires on 01/28/2023 11:00 AM CST

Med-Stop Code: 52230125657257

## 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 **GRIFFIE, DERRICK**

Donor Phone **(720) 742-9430**

Donor ID **CO021780541**

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

Laboratory **PHONE: FAX:**

Company Account

Med-Stop Code **52230125657257**

Not Later than **01/25/2023 11:00 AM CST UTC-6**

Test Type **DRUG TEST DOT REGULATED FMCSA 65304N**

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 - 2:00pm 11:00am - 7:00pm 2:00pm - 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: 52230125657257**