



---

**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:**

---

**ZIGI FREIGHT INC**  
**6850 W 63RD STREET**  
**CHICAGO IL 60638**  
**PHONE: (630) 485-7370**  
**FAX: (630) 485-6980**

**ATTENTION TO:**

---

**NIKOLA STAMENKOVIC**

**SUBJECT:**

---

**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

---

**02/08/2024 09:47 AM CST UTC-6**

**PAGES:**

---

**2**

**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:

**PRE-EMPLOYMENT**

COLLECTION DATE / TIME:

**01/25/2024 04:26 PM****CST UTC-6**

TEST RESULT:

**NEGATIVE**

SPECIMEN ID:

**CF15809905**

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****EMAIL: mro@med-stop.com**

TEST LAB PANEL:

**W215****THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

EMPLOYEE / APPLICANT:

**MERCED CINTRON, JUAN**

DONOR ID:

**FLM623420773350**

NAME OF COMPANY / LOCATION:

**ZIGI FREIGHT INC****6850 W 63RD STREET****CHICAGO IL 60638**

LOCATION / COLLECTION SITE:

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

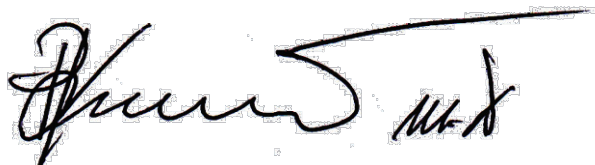
LABORATORY PERFORMING TEST:

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

MEDICAL REVIEW OFFICER:

**KWIECINSKI PAWEL K**

SIGNATURE:



LAB RESULT RECEIVED AT:

**01/26/2024 09:54 AM CST UTC-6**

MRO COPY BECAME AVAILABLE AT:

**01/25/2024 04:30 PM CST UTC-6**

DATE / TIME THE RESULT BECAME AVAILABLE:

**01/26/2024 10:00 AM CST UTC-6****THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 5 8 0 9 9 0 5

SPECIMEN ID NO.

CLIENT NO. YMS.DOT1.D2828543

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

ACCESSION NO.

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

Site Location

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

NIKOLA STAMENKOVIC  
ZIGI FREIGHT INC  
6850 W 63RD ST  
CHICAGO, IL 60638  
Phone#: (630)485-7370 / Fax#: (630)485-6980PAWEL KWIECINSKI, MD (MRO4478)  
MED-STOP INC  
9950 LAWRENCE AVE  
SUITE 403  
SCHILLER PARK, IL 60176  
Phone#: (877)633-3633 / Fax#: (847)647-6608**FL M623420773350**

C. Donor SSN, Employee I.D. No., or CDL State and No.

D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG  
E. 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) \_\_\_\_\_**W215**G. Collection Site Address: **Med Stop - Hickory Hills**

Collection Site Code:

Collector Contact Info: Phone **(708)546-0551****7831 W 95th St Ste J****YMS.0003**Fax **(708)295-9162****Hickory Hills, IL 60457-2388**Other **info@med-stop.com****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"/>        | <b>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</b>               |   |
|  | <input type="checkbox"/> UPS                                 | <input type="checkbox"/> FedEx                  |
| Signature of Collector                     | <input checked="" type="checkbox"/> Other <u>CRL Courier</u> |   |
| Agnieszka Horodowicz                       | 1/25/2024  | 4:26 CST PM <input checked="" type="checkbox"/> |
| (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"/> | JUAN MERCED CINTRON                    | 1/25/2024                           |
| Signature of Donor                  | (PRINT) Donor's Name (First, MI, Last) | Date (Mo/Day/Yr)                    |
| Email address: <u>N/A</u>           | Daytime Phone No. <u>4077592571</u>    | Evening Phone No. <u>4077592571</u> |
|                                     | Date of Birth                          | <u>9/15/1977</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)

COPY 2 - MEDICAL REVIEW OFFICER COPY