MED STOP

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:

7/27/2023 9:03 AM

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

SPECIMEN ID:

CF14001928

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

COLLECTION DATE / TIME:

7/10/2023 3:22 PM

TESTING AUTHORITY:

DOT FMCSA

TEST RESULT:

NEGATIVE

TEST LAB PANEL:

W215

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

EMPLOYEE / APPLICANT:

CAUZ, OMAR

DONOR ID:

FLC200640661870

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:

7/11/2023 10:19 AM

MRO COPY BECAME AVAILABLE AT:

7/10/2023 5:31 PM

DATE / TIME THE RESULT BECAME AVAILABLE:

7/11/2023 10:28 AM

THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

8433 Quivira Road
Lenexa, KS 66215

CRL

C F 1 4 0 0 1 9 2 8

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.
NIKOLA STAMENKOVIC
ZIGI FREIGHT INC
6850 W 63RD ST
CHICAGO, IL 60638
Phone#: (630)485-7370 / Fax#: (630)485-6980

Site Location

B. MRO Name, Address, Phone No. and Fax No.
PAWEL KWIECINSKI, MD   (MRO4478)
MED-STOP INC
9950 LAWRENCE AVE
SUITE 403
SCHILLER PARK, IL 60176
Phone#: (877)633-3633 / Fax#: (847)647-6608

FL C200640661870

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**
7831 W 95th St Ste J
Hickory Hills, IL 60457-2388

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: ☒ 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.

X _[signature]_

Signature of Collector

Dorota Moniuszko	7/10/2023	3:22 CDT AM ☐ PM ☒
(PRINT) Collector's Name (First, MI, Last)	Date (Mo/Day/Yr)	Time of Collection

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
☐ UPS   ☐ FedEx
☒ Other CRL Courier
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.

X _[signature]_
Signature of Donor

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

7/10/2023
Date (Mo/Day/Yr)

Email address: omarcauz6627@gmail.com   Daytime Phone No. 8135311003   Evening Phone No. 8135311003   Date of Birth

5/27/1966
(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)

COPY 2 - MEDICAL REVIEW OFFICER COPY

OMB No. 0930-0158