



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:

9/1/2023 4:46 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:

PRE-EMPLOYMENT

SPECIMEN ID:

CF14001448

COLLECTION DATE / TIME:

8/18/2023 2:09 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:

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

EMPLOYEE / APPLICANT:

QASEM, ANIS BASSAM

DONOR ID:

NC000030678406

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**

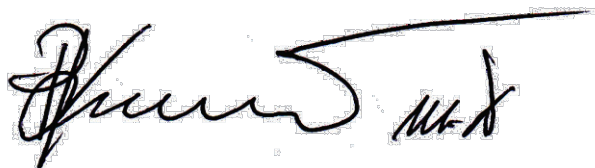
LABORATORY PERFORMING TEST:

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

MEDICAL REVIEW OFFICER:

KWIECINSKI PAWEL K

SIGNATURE:



LAB RESULT RECEIVED AT:

8/19/2023 10:48 AM

MRO COPY BECAME AVAILABLE AT:

8/18/2023 2:35 PM

DATE / TIME THE RESULT BECAME AVAILABLE:

8/19/2023 10:58 AM**THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 4 0 0 1 4 4 8

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.

Site Location

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

KOVACEVIC RADOSLAV
RIKI TRANSPORTATION INC
8225 LECLAIRE AVE
BURBANK, IL 60459
Phone#: (973)563-3159 / 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**NC 000030678406**

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.*

X Signature of Collector Agnieszka Horodowicz (PRINT) Collector's Name (First, MI, Last)	AM 8/18/2023 Date (Mo/Day/Yr) 2:09 CDT PM X Time of Collection	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: <input type="checkbox"/> UPS <input type="checkbox"/> FedEx <input checked="" type="checkbox"/> Other <u>CRL Courier</u> 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 of Donor	ANIS B QASEM (PRINT) Donor's Name (First, MI, Last)	8/18/2023 Date (Mo/Day/Yr)
Email address: <u>N/A</u>	Daytime Phone No. <u>9197982779</u>	Evening Phone No. <u>9197982779</u>
		2/9/1987 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:*
☐ **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)
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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)
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COPY 2 - MEDICAL REVIEW OFFICER COPY