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**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:**

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

**ATTENTION TO:**

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**NIKOLA STAMENKOVIC**

**SUBJECT:**

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**URINE DRUG TESTING RESULTS**

**DOCUMENT CREATED AT:**

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**9/12/2023 11:19 AM**

**PAGES:**

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**2**

**THIS SECURE FAX NUMBER HAS BEEN PROVIDED TO MED-STOP MRO SERVICES BY EMPLOYERS  
REPRESENTATIVE IDENTIFIED AS SAFETY OFFICER**

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**PLEASE FORWARD TO THE SAFETY OFFICER**

**CONFIDENTIAL**

**RESULTS OF SAMSHA (NIDA) CONTROLLED TEST**

PURPOSE OF TEST:

**PRE-EMPLOYMENT**

SPECIMEN ID:

**CF14327893**

COLLECTION DATE / TIME:

**9/6/2023 3:32 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:

**PARRA FONSECA, NESTOR  
YOBANY**

NAME OF COMPANY / LOCATION:

**ZIGI FREIGHT INC**

DONOR ID:

**FLP615639630150****6850 W 63RD STREET****CHICAGO IL 60638**

LOCATION / COLLECTION SITE:

**ARCPPOINT LABS OF FT LAUDERDA  
3221 NW 10TH TER  
FORT LAUDERDALE FL 33309  
PHONE: (954) 667-7908**

LABORATORY PERFORMING TEST:

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

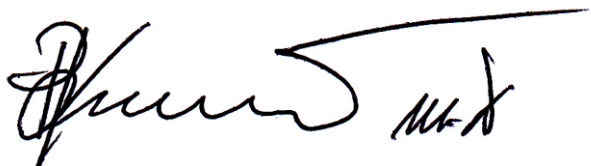
MEDICAL REVIEW OFFICER:

**KWIECINSKI PAWEL K**

LAB RESULT RECEIVED AT:

**9/7/2023 2:25 PM**

SIGNATURE:



MRO COPY BECAME AVAILABLE AT:

**9/6/2023 3:00 PM**

DATE / TIME THE RESULT BECAME AVAILABLE:

**9/7/2023 2:26 PM****THIS TEST WAS PERFORMED ACCORDING TO 49CFR.40 REGULATIONS**

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE





C F 1 4 3 2 7 8 9 3

SPECIMEN ID NO.

CLIENT NO. YMS.CMKT.D2828543

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

ACCESSION NO.

<b>A. Employer Name, Address, I.D. No.</b> NIKOLA STAMENKOVIC ZIGI FREIGHT INC 6850 W 63RD ST CHICAGO, IL 60638 Phone#: (630)485-7370 / Fax#: (630)485-6980		<b>Site Location</b>  	<b>B. MRO Name, Address, Phone No. and Fax No.</b> PAWEL KWIECINSKI, MD (MRO4478) MED-STOP INC 9950 LAWRENCE AVE SUITE 403 SCHILLER PARK, IL 60176 Phone#: (877)633-3633 / Fax#: (847)647-6608
<b>C. Donor SSN, Employee I.D. No., or CDL State and No.</b>  		<b>FLP615639630150</b>	
<b>D. Specify Testing Authority:</b> <input type="checkbox"/> HHS <input type="checkbox"/> NRC <b>Specify DOT Agency:</b> <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			
<b>E. Reason for Test:</b> <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) _____			
<b>F. Drug Tests to be Performed:</b> <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ <b>W215</b>			
<b>G. Collection Site Address:</b> <b>ARCpoint Labs of Fort</b> <b>3221 NW 10th Ter Ste 508</b> <b>Ft Lauderdale, FL 33309-5942</b>		<b>Collection Site Code:</b> <b>FGF.FORT</b>	<b>Collector Contact Info:</b> Phone <b>(954)667-7908</b> Fax <b>(954)951-1539</b> Other <b>MLasso@arcpointlabs.com</b>

**STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).**☒ URINE☐ ORAL FLUID

<b>COLLECTION:</b> <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.			
<b>URINE: Collector reads urine temperature within 4 minutes.</b> Temperature between 90° and 100°F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark			
<b>ORAL FLUID:</b> 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	
<b>REMARKS:</b>			

**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.

<b>X</b> Signature of Collector Daniel Oudkerk (PRINT) Collector's Name (First, MI, Last)	9/6/2023 Date (Mo/Day/Yr)	3:32 EDT PM X Time of Collection	<b>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</b> <input type="checkbox"/> UPS <input checked="" type="checkbox"/> FedEx <input type="checkbox"/> Other _____ Name of Delivery Service
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**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.

<b>X</b> Signature of Donor	NESTOR YOBANY PARRA FONSECA (PRINT) Donor's Name (First, MI, Last)	9/6/2023 Date (Mo/Day/Yr)
Email address: N/A	Daytime Phone No. 6304857370 Evening Phone No. 6304857370	Date of Birth 1/15/1963 (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"/> ADULTERATED (adulterant/reason): _____		
<input type="checkbox"/> SUBSTITUTED		
<input type="checkbox"/> OTHER: _____		
<input type="checkbox"/> TEST CANCELLED		
<b>REMARKS:</b>		
<b>X</b> 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: _____			
<b>REMARKS:</b>			
<b>X</b> 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