

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA MDEG WHOLESALER

NON PUBLICLY TRADED CORPORATION

FEE: **\$500.00** (non-refundable and not transferable) - Application must be printed legibly

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

New MDEG X Ownership Change _____ Name Change _____ Location Change _____
Please provide current license number if making changes: _____

FACILITY INFORMATION

Facility Name: KCI USA, Inc.

Physical Address: 6265 S. Valley View Blvd., Suite B C, Las Vegas, NV 89118

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 6103 Farinon Dr. Attn: HCC-Minerva Mendoza

City: San Antonio State: TX Zip Code: 78249

Telephone Number: (210) 255-6524 Fax Number: (210) 255-6121

E-mail: Minerva.Mendoza@kci1.com Website: www.kci1.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8a to 5p Tue: 8a to 5p Wed: 8a to 5p Thu: 8a to 5p

Fri: 8a to 5p Sat: on to call Sun: on to call Holidays: on to call

MDEG ADMINISTRATOR INFORMATION (Person who runs the facility on a daily basis)

Name: Russ Geiman

**Please complete the attached form. Must be included with the application.

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- Medical Gases
- Respiratory Equipment
- Life-sustaining equipment
- Diabetic Supplies
- Assistive Equipment
- Parenteral and Enteral Equipment
- Orthotics and Prosethics
- Other: Wound V.A.C. (Vacuum Assisted Closure)

Board Use Only
Received FEB 04 2011 Check Number 576 Amount 500-

55917
1320

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Kinetic Concepts, Inc.

Corporation Name: KCI USA, Inc.

Mailing Address: 6103 Farinon Dr. Attn: HCC-Minerva Mendoza

City, State and Zip: San Antonio, TX 78249

Telephone Number: (210) 255-6524 Fax Number: (210) 255-6121

License Contact Person: Minerva Mendoza

Professional Compliance Contact Person: Nancy Scheifele, VP Health Care Compliance

NAME AND TITLE OF EACH OFFICER AND DIRECTOR (Use separate sheet if necessary)

<u>Officer or director name</u>	<u>Officer or director title</u>
<u>Please see attached</u>	

For any corporation non publicly traded, disclose the following:

Kinetic Concepts, Inc. owns KCI USA, Inc. 100%

- 1) List any persons to whom the shares were issued by the corporation?
 - a) Kinetic Concepts, Inc. 8023 Vantage Dr. San Antonio, TX 78230

<u>Name</u>	<u>Address</u>
 - b)

<u>Name</u>	<u>Address</u>
 - c)

<u>Name</u>	<u>Address</u>
 - d)

<u>Name</u>	<u>Address</u>

NOTE: All persons who are stockholders must accurately complete a personal history record form.

- 2) Provide the number of shares issued by the corporation. _____
- 3) What was the price paid per share? _____
- 4) What date did the corporation actually receive the cash assets? _____
- 5) Provide a copy of the corporations stock register evidencing the above information.

If the non publicly traded corporation is a subsidiary, list name and state of incorporation of the parent corporation, and include a list of its officers.

Kinetic Concepts, Inc. Incorporated in Texas

List all Medicare and Medicaid WHOLESALER numbers registered to the business or its owner:

MCR # 0445090105 MCD # 003302666

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes No If yes, list the persons, their address and their business names.

a) _____
Name Address

Business

b) _____
Name Address

Business

c) _____
Name Address

Business

d) _____
Name Address

Business

- 2) Are you or have you in the last 10 years been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes No If yes, list the persons, their address and their business names.

a) _____
Name Address

Business

b) _____
Name Address

Business

c) _____
Name Address

Business

3) Are any of the owners health professionals? If yes, please list name. N/A

___ Practitioner	Name: _____
___ Advanced Practitioner of Nursing	Name: _____
___ Physician's Assistant	Name: _____
___ Physical Therapist	Name: _____
___ Occupational Therapist	Name: _____
___ Registered Nurse	Name: _____
___ Respiratory Therapist	Name: _____

Within the last five (5) years:

- 4) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes No
- 5) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been denied a license, permit or certificate of registration? Yes No
- 6) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes No
- 7) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes No
- 8) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes No

If the answer to any question 4 through 8 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG WHOLESALER may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.


Signature of corporation officer

01/20/2011
Date

Jason R. Cone - Sr. VP, Quality, Regulatory, Safety and Compliance

Type name and title

APPLICATION TO BE THE MDEG ADMINISTRATOR
Person who runs the facility on a daily basis

Date 11/7/11

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for MDEG Wholesaler
.....
Nature of MDEG
KCI USA, Inc. 6265 S. Valley View Blvd, Ste. B C, Las Vegas, NV 89118
.....
Name and Address of Business for Which MDEG Administrator Is Requested
KCI USA, Inc.
.....
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

JUAREZ

Last Name

KENNETH

First Name

MARIO

Middle Name

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

8992 DUSSELDORF WAY - LAS VEGAS NV 89147

Present Residence Address-Street or RFD

City

State/Zip

6265 S. VALLEVIEW BLVD Las Vegas NV 89118

Present Business Address SUTE B & C

City

State/Zip

MANAGING SUPERVISOR Dates

Present Position with the MDEG

Phone: () _____

Fax: _____

Email address: KENNETH.JUAREZ@KCLM.COM

LOS ANGELES, CALIF
Place of Birth (City, County, State)

44
Age

M
Sex

BROWN
Color of Eyes

BLACK
Color of Hair

240
Weight

6' 2"
Height

Scars, tattoos or distinguishing marks and/or characteristics N/A

Are you a citizen of the United States? Yes No

If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

6-1990	KCI USA INC 6265 S. VALLEY VIEW BLVD SUITE B ³ C LAS VEGAS NV 89118	174,720
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
MANAGING SUPERVISOR	RUN DAILY OPERATION	KENNETH JUAREZ
Title	Description of Duties	Name of Supervisor

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
----------------	------------------------------------	----------------------

Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
----------------	------------------------------------	----------------------

Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
----------------	------------------------------------	----------------------

Title	Description of Duties	Name of Supervisor
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I have I have not been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have I have not been charged, arrested or convicted of a felony or misdemeanor.
2. I have I have not been the subject of an administrative action whether completed or pending.
3. I have I have not had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4. Will you be actively involved in and an operation of the MDEG?

Yes No

5. Will you be employed fulltime with the

Yes No

6. Will you be present at the site of the M during its normal operating hours?

Yes No

If you answer No to questions 4, 5 or 6 please

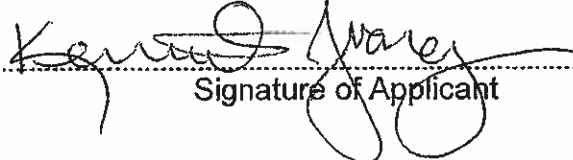
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.....
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.....
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Date of photograph 1/7/11

I, KENNETH JUAREZ, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.


.....
Signature of Applicant

Blank

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA MDEG WHOLESALER

NON PUBLICLY TRADED CORPORATION

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New MDEG Ownership Change _____ Name Change _____ Location Change _____
Please provide current license number if making changes: _____

FACILITY INFORMATION

Facility Name: KCI USA, Inc.

Physical Address: 1360 Greg St., Suite 106-107 Sparks, NV 89431-6093
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 6103 Farinon Dr. Attn: HCC-Minerva Mendoza

City: San Antonio State: TX Zip Code: 78249

Telephone Number: (210) 255-6524 Fax Number: (210) 255-6121

E-mail: Minerva.Mendoza@kci1.com Website: www.kci1.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8a to 5p Tue: 8a to 5p Wed: 8a to 5p Thu: 8a to 5p
Fri: 8a to 5p Sat: on to call Sun: on to call Holidays: on to call

MDEG ADMINISTRATOR INFORMATION (Person who runs the facility on a daily basis)

Name: Harry Boniface

**Please complete the attached form. Must be included with the application.

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- Medical Gases
- Respiratory Equipment
- Life-sustaining equipment
- Diabetic Supplies
- Assistive Equipment
- Parenteral and Enteral Equipment
- Orthotics and Prosthesis
- Other: Wound V.A.C. (Vacuum Assisted Closure)

Board Use Only
Received FEB 13 2011 Check Number 577 Amount 500.00

56034
1238

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Kinetic Concepts, Inc.

Corporation Name: KCI USA, Inc.

Mailing Address: 6103 Farinon Dr. Attn: HCC-Minerva Mendoza

City, State and Zip: San Antonio, TX 78249

Telephone Number: (210) 255-6524

Fax Number: (210) 255-6121

License Contact Person: Minerva Mendoza

Professional Compliance Contact Person: Nancy Scheifele, VP Health Care Compliance

NAME AND TITLE OF EACH OFFICER AND DIRECTOR (Use separate sheet if necessary)

Officer or director name

Officer or director title

Please see attached

For any corporation non publicly traded, disclose the following:

Kinetic Concepts, Inc. owns KCI USA, Inc. 100%

1) List any persons to whom the shares were issued by the corporation?

a) Kinetic Concepts, Inc. 8023 Vantage Dr. San Antonio, TX 78230

Name

Address

b)

Name

Address

c)

Name

Address

d)

Name

Address

NOTE: All persons who are stockholders must accurately complete a personal history record form.

2) Provide the number of shares issued by the corporation. _____

3) What was the price paid per share? _____

4) What date did the corporation actually receive the cash assets? _____

5) Provide a copy of the corporations stock register evidencing the above information.

If the non publicly traded corporation is a subsidiary, list name and state of incorporation of the parent corporation, and include a list of its officers.

Kinetic Concepts, Inc. Incorporated in Texas

List all Medicare and Medicaid WHOLESALER numbers registered to the business or its owner:

MCR # 0445090118 MCD # 003316024

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes No If yes, list the persons, their address and their business names.

a) _____
Name Address

Business

b) _____
Name Address

Business

c) _____
Name Address

Business

d) _____
Name Address

Business

- 2) Are you or have you in the last 10 years been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes No If yes, list the persons, their address and their business names.

a) _____
Name Address

Business

b) _____
Name Address

Business

c) _____
Name Address

Business

- 3) Are any of the owners health professionals? If yes, please list name.
- | | | |
|---|-----------------|-------------|
| <input type="checkbox"/> Non practicing Physician | James Leininger | Name: _____ |
| <input type="checkbox"/> Practitioner | | Name: _____ |
| <input type="checkbox"/> Advanced Practitioner of Nursing | | Name: _____ |
| <input type="checkbox"/> Physician's Assistant | | Name: _____ |
| <input type="checkbox"/> Physical Therapist | | Name: _____ |
| <input type="checkbox"/> Occupational Therapist | | Name: _____ |
| <input type="checkbox"/> Registered Nurse | | Name: _____ |
| <input type="checkbox"/> Respiratory Therapist | | Name: _____ |

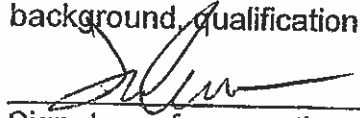
Within the last five (5) years:

- 4) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes No
- 5) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been denied a license, permit or certificate of registration? Yes No
- 6) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes No
- 7) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes No
- 8) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes No

If the answer to any question 4 through 8 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG WHOLESALER may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.



 Signature of corporation officer

2/2/2011

 Date

Jason R. Cone - Sr. VP, Quality, Regulatory, Safety and Compliance

 Type name and title

APPLICATION TO BE THE MDEG ADMINISTRATOR
Person who runs the facility on a daily basis

Date 1/11/2011

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

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All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for MDEG Administrator

Nature of MDEG

KCI USA, Inc. 1360 Greg St., Suite 106-107 Sparks, NV 89431-6093

Name and Address of Business for Which MDEG Administrator Is Requested
KCI USA, Inc.

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

BONIFACE III
Last Name

HARRY
First Name

ANTHONY
Middle Name

NONE
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

10030 GABRO ST RENO NV 89506
Present Residence Address-Street or RFD City State/Zip

1360 GREG ST Dates 5-16-04 - PRESENT SPARKS NV 89431
Present Business Address City State/Zip

WORKING SUPERVISOR Dates 5-16-04 - PRESENT
Present Position with the MDEG

Phone: _____ Fax: _____

Email address: HARRY.BONIFACEIII@KCI1.COM

_____ HoyLoke, MA
Date of Birth Place of Birth (City, County, State)

52 _____ MALE
Age Sex

HAZEL BROWN 182 Lbs 5'9"
Color of Eyes Color of Hair Weight Height

Scars, tattoos or distinguishing marks and/or characteristics TATTOO, LEFT SHOULDER ON
BACK OF A BULLDOG WITH SEMPER PARVUS UNDERNEATH

Are you a citizen of the United States? Yes No

If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

5-16-2004 - Present	KOJ 1360 GREG ST SPARKS NV 89431	13,520 hours
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Working Supervisor	Service Center Supervisor	JAMES NOONAN
Title	Description of Duties	Name of Supervisor

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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I have I have not been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have I have not been charged, arrested or convicted of a felony or misdemeanor.
2. I have I have not been the subject of an administrative action whether completed or pending.
3. I have I have not had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information and provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes No

5 .Will you be employed fulltime with the MDEG? Yes No

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes No



provide a written letter of explanation.

ATTACH PHOTOGRAPH

TAKEN WITHIN LAST

30 DAYS HERE

Date of photograph 1-11-2011

MDEG Administrator

I, HARRY ANTHONY BONIFACETH, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Harry A BonifaceTH
Signature of Applicant

Blank

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA MDEG PROVIDER

SOLE OWNER

FEE: \$500.00 (non-refundable and not transferable) - Application must be printed legibly

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

New MDEG Ownership Change _____ Name Change _____ Location Change _____

FACILITY INFORMATION

Facility Name: Orthopedic Motion, Inc.

Physical Address: 3233 W. Charleston Blvd, Suite #111 (This must be a business address, we can not issue a license to a home address)

Mailing Address: 3233 W. Charleston Blvd, #111

City: Las Vegas State: NV Zip Code: 89102

Telephone Number: 702-697-7070 Fax Number: 702-697-7077

E-mail: Website: www.orthopedicmotion.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8am to 5pm Tue: 8am to 5pm Wed: 8am to 5pm Thu: 8am to 5pm Fri: 8am to 5pm Sat: 24-Hour On-Call Services, 1 days a week Sun: Holidays: to

MDEG ADMINISTRATOR INFORMATION (Person who runs the facility on a daily basis)

Name: Brittany Stryker

**Please complete the attached form. Must be included with the application.

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- Medical Gases Assistive Equipment
Respiratory Equipment Parenteral and Enteral Equipment
Life-sustaining equipment Orthotics and Prosthesis
Diabetic Supplies Other:

Board Use Only Received FEB 6 2011 Check Number 534 Amount 500.00

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.

Owner's Name: Alan J. Goodin

List all previous names: _____

Social Security Number: _____

Date of Birth: _____

Place of Birth: _____ State: _____ Country: Korea

Citizenship: USA other _____

If applicable, list Naturalization Number: _____ Passport Number: _____

Current residence address: 4316 Jordan Court

City: Las Vegas State: NV Zip Code: 89129

Telephone Number: _____ Fax Number: _____

Previous address (last 5 years): Same as above

Address: _____ City: _____ State: _____ Zip Code: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Business Name: Orthopedic Motion, Inc.

Current Business Address: 2800 E. Desert Inn Road, #250

City: Las Vegas State: NV Zip Code: 89121

Telephone Number: 702-697-7070 Fax Number: 702-697-7077

Previous Employment (last 5 years):

Name: same Address: _____

City: _____ State: _____ Zip Code: _____

Name: same Address: _____

City: _____ State: _____ Zip Code: _____

Name: same Address: _____

City: _____ State: _____ Zip Code: _____

List all Medicare and Medicaid provider numbers registered to the business or its owner:

Medicare 0618600001

Medicaid 003302088

1) Do you hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes No If yes, list the persons, their address and their business names.

a) _____
Name Address

_____ Business

b) _____
Name Address

_____ Business

c) _____
Name Address

_____ Business

d) _____
Name Address

_____ Business

2) Have you in the last 10 years been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes No If yes, list the persons, their address and their business names.

a) _____
Name Address

_____ Business

b) _____
Name Address

_____ Business

c) _____
Name Address

_____ Business

3) Are you are a health professional?

- ___ Practitioner
- ___ Advanced Practitioner of Nursing
- ___ Physician's Assistant
- ___ Physical Therapist
- ___ Occupational Therapist
- ___ Registered Nurse
- ___ Respiratory Therapist

Within the last five (5) years:

- 4) Have you ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes No
- 5) Have you ever been denied a license, permit or certificate of registration? Yes No
- 6) Have you ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes No
- 7) Have you, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes No
- 8) Have you ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes No

If the answer to any question 4 through 8 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG provider may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Alan J. Goodin
Signature of owner

01.19.2011
Date

Alan J. Goodin
Type name

APPLICATION TO BE THE MDEG ADMINISTRATOR
Person who runs the facility on a daily basis

Date 01.19.11

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Nevada MDEG Wholesaler
Nature of MDEG
Orthopedic Motion, Inc. 3233 W. Charleston Blvd. Suite #111, Las Vegas, NV 891
Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Stryker. Last Name Brittany First Name Rose Middle Name

Brittany ROSE Bennett (Maiden Name)
Alias(es, nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

10464 Bay Ginger Lane Present Residence Address-Street or RFD Las Vegas City NV 89135 State/Zip

2800 E. Desert Inn Road #250 Present Business Address 2/19/2008-present Dates Las Vegas City NV 89121 State/Zip

Practice Manager Present Position with the MDEG 2/19/2008-present Dates

Phone: _____ Fax: _____

Email address: _____

Las Vegas, NV (Clark County) Place of Birth (City, County, State)

21 Date of Birth

Age Social Security Number _____ Sex Female

Blue Color of Eyes Blonde Color of Hair 160 Weight 5'7" Height

Scars, tattoos or distinguishing marks and/or characteristics NA

Are you a citizen of the United States? Yes No

If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

2000 E. Desert Inn Road, Suite 121
Las Vegas, NV 89121

02/2008-present	Orthopedic Motion, Inc.	40+ hrs/week · 3 years = 5,
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Cert. Orthotist/Prosthetist + Practice Manager	Manage all locations; provide orth. + pros. care to patients	Alan Goodin, Sr.
Title	Description of Duties	Name of Supervisor
12/2006-02/2008	Hanger Prosthetics + orthotics	40+ hrs/week · 14 mths = 2
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist, Resident	526 South Tonopah Drive # 120 fitted patients w/ custom + off-the-shelf devices	Edward Sisson
Title	Description of Duties	Name of Supervisor
05/2006-08/2006	Barnes-Jewish Hospital	490 hrs.
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
OT Rotation	1 Barnes-Jewish Hospital Plaza St. Louis, MO residency tailored to at-risk children; assisting in treatment + recovery for patients	Name of Supervisor
Title	Description of Duties	Name of Supervisor
05/2005-08/2005	Health South Rehab	490+ Hours
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
OT Rotation	1250 South Valley View Drive, Las Vegas, NV geriatric orthopedic rehab + pediatric neuro. rehab.	Name of Supervisor
Title	Description of Duties	Name of Supervisor
03/2004	Procure (15664 W. Maple Road Omaha NE)	160 + Hours
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
OT Rotation	geriatric orthopedic rehab + pediatric neuro. rehab.	Name of Supervisor
Title	Description of Duties	Name of Supervisor
10/2003	Bergan Mercy Hospital	160 + Hours
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
OT Rotation	1500 Mercy Road Omaha, NE geriatric orthopedic Rehab	Name of Supervisor
Title	Description of Duties	Name of Supervisor
	pediatric neuro. rehab	

I have I have not been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have I have not been charged, arrested or convicted of a felony or misdemeanor.
2. I have I have not been the subject of an administrative action whether completed or pending.
3. I have I have not had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information and provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes No

5 .Will you be employed fulltime with the MDEG? Yes No

6 .Will you be present at the site of the MDEG during its normal operating hours?

If you answer No to questions 4, 5 or 6 please provide a written letter of

.....
.....
.....
.....
.....

ATTACH P

TAKEN V

30 DAY

Date of photograph



I, Brittany Stryker....., being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Brittany Stryker
Signature of Applicant

PERSONAL HISTORY RECORD

Date 01.19.2011

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, attach a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made herein is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Nevada MDEG Wholesaler
Orthopedic Motion, Inc. 3233 W. Charleston Blvd, Suite 111, Las Vegas, NV
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Groodin Alan John
Last Name First Name Middle Name

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

4316 Jordan Court Las Vegas NV 89129
Present Residence Address-Street or RFD City State/Zip

2000 E. Desert Inn Rd. Las Vegas, NV 89121 4/1993-present
Present Business Address City State/Zip Dates

Owner + President 702-697-7070
Occupation Dates Phone:

Pusan, Korea 702 702 702
Place of Birth (City County State) Residence Business Fax

49 Male
Age Sex

Brown Black White 210 Medium 6'1"
Color of Eyes Color of Hair Complexion Weight Build Height

Scars, tattoos or distinguishing marks and/or characteristics na

Are you a citizen of the United States? Yes No If alien, registration No

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single Married Separated Divorced Widowed Engaged

Applicant's initial AG

MARITAL INFORMATION-Continued

A. **Current Marriage** 09/25/1999 Kalamazoo Portage, Michigan
 Spouse's full name (Maiden) ^{Date} MARCI E ANN HOZEK ^{City} S
 Date of Birth _____ Place of Birth Kalamazoo, Michigan
 Resident address 1111 St. Las Vegas NV 89129
Street City State Zip
 Telephone: Residence (702) 256-0530 Business () _____
 Spouse's employer N/A Occupation _____
 Address of employer _____
Street City State Zip

B. **Previous Marriages:** If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
Rebecca	1998	1995	DIVORCE	Negril, Jamaica
Cynthia	1989	1987	DIVORCE	LAS VEGAS, NV
Tammy	1984	1982	DIVORCE	LAS VEGAS, NV

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone
Rebecca	UNKNOWN				
Cynthia	UNKNOWN				
Tammy	555 KEEN DRIVE	GRANTS PASS, OR		97527	54-956

3. **FAMILY INFORMATION:**

A. **Children and Dependents:**

List all children, including step-children and adopted children and give the following information:

Birth Date	Birth Place	Residence Address
—	—	—
—	—	—
—	—	—

B. **Child Support Information:**

Please mark the appropriate response:

- I am not subject to a court order for the support of child.
- I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or
- I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial AG Page _____

FAMILY INFORMATION-Continued

District attorney or public agency responsible for enforcing the child support order:

Name N/A

Address _____

Contact person _____

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parent-in-law or legal guardian. If retired or deceased, list last address and occupation.

Name (Maiden)	Birth Date	Address	Occupation
Father <u>John F. Goodin</u>			<u>Policeman deceased</u>
Mother <u>Jae Lee</u>		<u>2924 Copper Beach Ct. Las Vegas, NV 89117</u>	<u>Business owner</u>
Father-in-Law <u>Thomas Husek</u>		<u>482 Shadetree Trail Mason, MI 48854</u>	<u>GM Manager Retired</u>
Mother-in-Law <u>Connie Husek</u>		<u>482 Shadetree Trail Mason, MI 48854</u>	<u>Salesperson</u>

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
Spouse <u>Sharon Goodin</u>		<u>3582 Red First Las Vegas, NV 89135</u>	<u>Business owner</u>

Spouse

Spouse <u>Linda Goodin</u>		<u>7169 Sugar Leaf Place Las Vegas, NV 89148</u>	<u>Business owner</u>
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Spouse

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	<u>IS 51</u>	<u>Staten Island, NV</u>	<u>13-77</u>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School	<u>Clark</u>	<u>Las Vegas, NV</u>	<u>77-79</u>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University	<u>Clark County Community College</u>	<u>Las Vegas, NV</u>	<u>79-81</u>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Other				Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any _____

College or university where obtained _____

Applicant's initial AG

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes No

Branch Date of entry-active service

Date of separation Type of discharge

Rating at separation Serial number

While in the military service were you ever arrested for an offense which resulted in summary action, a trial special or general court martial? Yes No If yes, furnish details on separate sheet. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes No

County State Date registered

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citation) Yes No If yes, give details in space provided below and provide a written explanation. List all cases without exception.

Date of Arrest	Age	Charge	Location-City and State	Deposition/Date	Arresting Agency

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were arrested or in which you were named as an unindicted co-party? Yes No

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes No

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes No

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes No

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes No
If yes, when? city, county and state

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes No
If yes when? city, county and state

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes No
If you answer to any of the above questions (B through H) is yes, please provide a written explanation.

Name	Relationship	Charge	Location	Date

- I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?
 Yes No (Other than divorces)

If yes, give details below and provide a written explanation. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date

- J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy? Yes No If yes, complete the following and provide a written explanation.

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
12/99 - Present	4316 Jerdon Court	Las Vegas	NV
9/2 - 12/99	7612 Belondo Ln.	Las Vegas	NV
84 - 92	1012 Interlude Dr.	Las Vegas	NV
82 - 84	5613 Bartlett Ave.	Las Vegas	NV
77 - 82	3763 Topana St.	Las Vegas	NV
72 - 77	322 Woodbineter	Staten Island	NY

5. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
04/93-present	Orthopedic Motion, Inc. 2800 E. Desert Inn Road, Suite 250 Las Vegas, NV 89121	
Owner	Owner	
12/85 - 12/95	Desert Orthopedic Center 2800 Desert Inn Rd Ste #100 LV NV 89121	To run business
Orthopedic assistant	assist in surgery & see patients	Milce Pendel
12/81 - 12/85	UMC 1100 W. Charleston LV NV	New Job
Surg. Tech	Assist Surgeon in O.R.	Starr
09/81 - 12/81	Valley Hospital 1020 Shadow Lane LV NV	To work for UMC
Orderly	transport patients	can't remember
10/79 - 09/81	Sunrise Hospital 3186 Maryland Pkwy LV NV	School
Orderly	Transport patients	can't remember
12/78 - 09/79	Seas Maryland Pkwy LV NV	Hours
Night Janitor	cleaning of the store	can't remember
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor

If additional space is needed, please provide an attachment.

Applicant's initial AB Page

5. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name <u>Mark Barry MD</u>	<u>Home</u>				()	
Employer <u>D.O.C.</u>		Business <u>2800 E. Desert Inn</u>		<u>LV NV 89121</u>	()	<u>8+</u>
Name <u>Johnathan Camp MD</u>	<u>Home</u>				()	
Employer <u>Self</u>		Business <u>1525 Windmill Ln</u>	<u>LV NV</u>	<u>89123</u>	()	<u>8+</u>
Name <u>Thomas Dunn MD</u>	<u>Home</u>				()	
Employer <u>D.O.C.</u>		Business <u>2800 Desert Inn</u>	<u>LV NV</u>	<u>89121</u>	()	<u>8+</u>
Name <u>Jaswinder Grover MD</u>	<u>Home</u>				()	
Employer <u>Nevada Spine</u>		Business <u>7140 Smoke Ranch</u>		<u>LV NV 89128</u>	()	<u>1 8+</u>
Name <u>Troy Watson MD</u>	<u>Home</u>				()	
Employer <u>DOC</u>		Business <u>2800 Desert Inn</u>	<u>LV NV</u>	<u>89121</u>	()	<u>8+</u>

10. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:
- | | | | | |
|------------|------------|--------------------------------|----------------------|-----------|
| Liquor | Lawyer | Race horse/race dog owner | Securities dealer | Insurance |
| Doctor | Contractor | Real estate broker or salesman | Barber/Cosmetologist | Gaming |
| Accountant | Pilot | Sports promoter | Trainer or manager | Educator |
- Yes No
- If yes, state type, where and years held

11. Have you ever applied for a city, county or state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes No
- If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

12. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada, any reason whatsoever? Yes No If yes, please provide details and a written explanation.

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupation or professional activity? Yes No If yes, please provide details and a written explanation

If yes to the above, state where, when and for what reason:

14. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes No If yes, please provide details and a written explanation

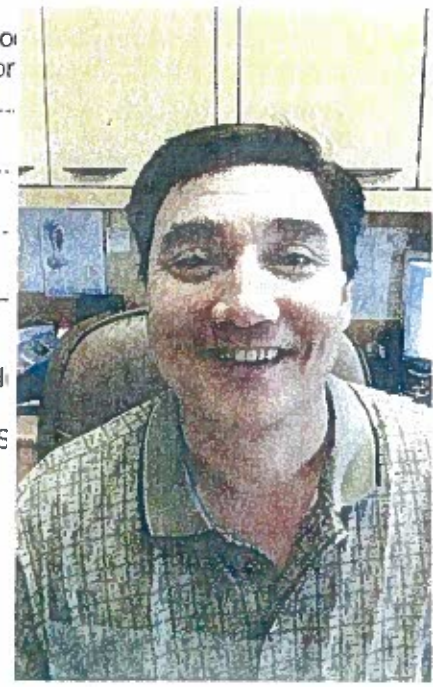
15. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes No If yes, please provide details and a written explanation

16. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/ controlled substances? Yes No If yes, please provide details and a written explanation.

17. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary closure)? Yes No If yes, please provide details and written explanation

18. Do you have any relatives within the fourth degree of consanguinity associated with the pharmaceutical or drug related industry? Yes No If yes, please provide details and written explanation

ATTACH PHOTOGRAPH
WITHIN LAST 60 DAYS



Date of photograph 11/18/2011

Applicant's initial AG

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