NEVADA STATE
BOARD OF PHARMACY

BOARD MEETING

June 5-6, 2019

HYATT PLACE
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RENO, NEVADA

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NEVADA STATE BOARD OF PHARMACY

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MINUTES

April 10 & 11, 2019

BOARD MEETING

Hilton Garden Inn
7830 S Las Vegas Boulevard
Las Vegas, Nevada

Board Members Present:

Jason Penrod	Kevin Desmond	Jade Jacobo	Wayne Mitchell
Melissa Shake	Robert Sullivan	Gener Tejero	

Board Staff Present:

Dave Wuest	Yenh Long	Paul Edwards	Brett Kandt
Shirley Hunting	Joe Dodge	Kenneth Scheuber	Luis Curras
Dena McClish	Leo Basch	Kristopher Mangosing	
Sophia Long			

President Penrod read the mission statement of the Nevada State Board of Pharmacy to reiterate the Board's duty to carry out and enforce the provisions of Nevada Law to protect the health, safety, and welfare of the public.

Mr. Wuest explained that Wayne Mitchell would be absent the morning of April 10, 2019, due to a previous engagement.

1. Public Comment April 10, 2019 9:00 AM

Dr. Farzad Kumyar, appeared and expressed concern regarding pharmacies not carrying certain medications. He stressed the importance of a patient's ability to reliably get their medications.

2. Approval of March 6-7, 2019, Minutes

Board Action:

Motion: Kevin Desmond moved to approve the March 6-7, 2019, Meeting Minutes as presented.

Second: Melissa Shake

Action: Passed unanimously

3. Applications for Out-of-State Pharmacy – Non Appearance

A. Aon Pharmacy – Fort Myers, FL
B. BioMatrix Specialty Pharmacy of Maryland, LLC – Columbia, MD
C. Canary Pharmacy – Montclair, CA
D. Dania Discount Drug – Dania Beach, FL
E. DermRx Pharmacy – Dallas, TX
F. Factor One Source Pharmacy LLC – Cumberland, MD
G. Ruskin Pharmacy – Ruskin, FL
H. Sortpak Pharmacy – Glendale, CA
I. Springs Drug Store – Miami Shore, FL
J. Sterling Pharmacy, Inc. – Jermyn, PA
K. Superior Drugmart – Flushing, NY
L. U-Med Inc. – Granby, CO
M. WhiteGloveRx – Aventura, FL

Applications for Out-of-State Compounding Pharmacy – Non Appearance

N. Powerhouse Pharmacy – Dallas, TX
O. Physicians Preference Pharmacy International LLC – Katy, TX
P. Premier Pharmacy Group LLC – Colorado Springs, CO
Q. Saddlebrook Pharmacy – Tomball, TX

Applications for Out-of-State Wholesaler – Non Appearance

R. ACADIA Pharmaceuticals Inc. – San Diego, CA
S. Adamas Pharma, LLC – Emeryville, CA
T. Alembic Pharmaceuticals, Inc. – Bridgewater, NJ
U. Avita Medical Americas, LLC – Valencia, CA
V. Bausch Health US, Inc. – Bridgewater, NJ
W. Chiesi USA, Inc. – Cary, NC
X. DHL Supply Chain (USA) – Whitestown, IN
Y. Dompe U.S. Inc. – Boston, MA
Z. Dukal Corporation – Ronkonkoma, NY
AA. Edenbridge Pharmaceuticals, LLC – Parsippany, NJ
BB. Eversana Life Science Services, LLC – Fontana, CA
CC. Evoke Pharma, Inc. – Solana Beach, CA
DD. Fluvaccine.org Inc – Salt Lake City, UT
EE. Fougera Pharmaceuticals Inc. – Melville, NY
FF. Geodis Logistics LLC – McDonough, GA

GG. Gelesis, Inc. – Boston, MA
HH. Insmed Incorporated – Bridgewater, NJ
II. Ipsen Biopharmaceuticals, Inc. – Basking Ridge, NJ
JJ. Isopure, Corp. – Louisville, KY
KK. Otsuka America Pharmaceutical, Inc. – Rockville, MO
LL. Premier Rx Wholesale – Cincinnati, OH
MM. RAS Enterprises LLC – Gulfport, MS
NN. Sandoz Inc. – Princeton, NJ
OO. Saptalis Pharmaceuticals, LLC – Hauppauge, NY
PP. SCILEX Pharmaceuticals Inc. – Mission Viejo, CA
QQ. SOLA Pharmaceuticals – Baton Rouge, LA
RR. St. Renatus, LLC – Fort Collins, CO
SS. Viona Pharmaceuticals Inc. – Cranford, NJ
TT. Wright Medical Technology, Inc. – Arlington, TN

Applications for Out-of-State Medical, Devices, Equipment and Gases – Non Appearance

UU. Aeroflow Urology, LLC – Arden, NC
VV. Buffalo Respiratory Therapy, LLC – Williamsville, NY
WW. Current Medical Technologies, Inc. – Lakeville, MA
XX. Dee Veterinary Products, LLC – Miami Gardens, FL
YY. DHL Supply Chain (USA) – Southhaven, MS
ZZ. Empatica, Inc. – Boston, MA
AAA. Liebel-Flarsheim Company LLC – Cincinnati, OH

Application for Nevada Warehouse – Non Appearance

BBB. GEODIS Logistics LLC – Sparks, NV

Applications for Nevada Pharmacy – Non Appearance

CCC. The ER at Blue Diamond – Las Vegas, NV
DDD. Walgreens #21159 – Las Vegas, NV

Melissa Shake recused from participation regarding Item 3 DDD. due to her employment with Walgreens.

Melissa Shake disclosed that the managing pharmacist of 3 CCC. was formerly an intern at her store, but stated that she could participate fairly and without bias.

Board Action:

Motion: Kevin Desmond moved to approve the Consent Agenda with the exception of Item 3 DDD.

Second: Robert Sullivan

Action: Passed unanimously

Board Action:

Motion: Kevin Desmond moved to approve Item 3 DDD.

Second: Robert Sullivan

Action: Passed unanimously

4. Discipline

A. Jaime Cordoba-Hernandez, R.Ph (17-070-RPH-S)

Jade Jacobo disclosed that in the past Mr. Cordoba-Hernandez he interviewed for a job with her, but stated that she could participate in this matter fairly and without bias.

Jaime Cordoba-Hernandez appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Bill Stilling was present as counsel representing Mr. Cordoba-Hernandez.

Gener Tejero disclosed that Mr. Stilling is his attorney, but stated that he could participate in this matter fairly and without bias.

Mr. Edwards explained that Mr. Cordoba-Hernandez has agreed to Stipulated Facts and requested the Board's permission to have Ms. Long read the facts into the record.

President Penrod allowed Ms. Long to read the Stipulated Facts into the record.

Ms. Long read the Stipulated Facts into the record. The facts outlined Mr. Cordoba-Hernandez's past discipline with the Board and described the facts of the case where in July 2017 Dr. Dhaval Shah sent a prescription to Alta Care Home Heath (Alta Care) for IV Vancomycin 1 G every 12 Hr for 2 weeks for patient P.L. The physician stated on that prescription that "Pharm to dose Abx" and "Vanco trough weekly."

Justin Reyes from Alta Care Home Health contacted All City Pharmacy regarding the prescription. Mr. Cordoba-Hernandez told Mr. Reyes that All City Pharmacy could provide the intravenous medication, but would be sending the Vancomycin without supplies. Alta Care faxed the prescription to the pharmacy.

Mr. Cordoba-Hernandez accepted a verbal prescription from Mr. Reyes to change the Vancomycin quantity to 30 vials, instead of 28 vials as Dr. Shah prescribed. Mr. Reyes is not a practitioner and is not an agent of Dr. Shah.

Mr. Cordoba-Hernandez prepared and dispensed 30 Vancomycin 1 gm vials that were delivered to the patient's home without the diluent for intravenous administration.

R.N. Gerlie Comahig of Alta Care contacted Mr. Cordoba-Hernandez regarding the missing infusion supplies and medications. Mr. Cordoba-Hernandez accepted a verbal prescription from Ms. Comahig for Sodium Chloride 0.9% flushing solution and Heparin 100u/ml flushing solution. Ms. Comahig is not a practitioner and is not an agent of Dr. Shah.

The labels for each medication list Dr. Shah as the ordering practitioner.

Mr. Edwards stated that All City Pharmacy did not dispute the Stipulated Facts in their Answer and Notice of Defense.

Mr. Stilling did not contest the Stipulated Facts.

Mr. Edwards requested the Board withdraw the Second Cause of Action due to lack of evidence.

Board Action:

Motion: Kevin Desmond moved to accept the Stipulated Facts as presented.

Second: Gener Tejero

Action: Passed unanimously

Mr. Stilling called Mr. Cordoba-Hernandez as a witness.

Mr. Cordoba-Hernandez described his work and education history.

The Board questioned Mr. Cordoba-Hernandez regarding his hospital and infusion pharmacy experience.

After discussion the Board expressed concern regarding Mr. Cordoba-Hernandez's lack of knowledge necessary for infusion pharmacy.

Board Action:

Motion: Melissa Shake moved to find Jaime Cordoba-Hernandez guilty of the First Cause of Action.

Second: Jade Jacobo

Action: Passed unanimously

Board discussion ensued regarding potential penalties for Mr. Cordoba-Hernandez.

Mr. Edwards moved to have Exhibit 1 admitted into the record.

Mr. Stilling had no objections.

President Penrod admitted Exhibit 1 into the record.

Mr. Edwards presented Exhibit 1, a list of reasonably and actually incurred costs.

Board Action:

Motion: Melissa Shake moved to revoke Jaime Cordoba-Hernandez's Nevada Pharmacist Registration. The revocation is stayed and his registration place on probation for 4 years. Mr. Cordoba-Hernandez must take and pass the NAPLEX and MPJE within 6 months. Mr. Cordoba-Hernandez shall attend two Board Meetings a year on discipline day for the time he is on probation. Mr. Cordoba-Hernandez shall pay a $5,000 fine and $1,250 administrative fee.

Second: Kevin Desmond

Action: Passed unanimously

B. All City Pharmacy, LLC (17-070-PH-S)

There was no representative present for All City Pharmacy, LLC.

Mr. Edwards explained that the facts in this case are the same as with Mr. Cordoba-Hernandez.

Mr. Edwards moved to have Exhibit 1 and 4 admitted into the record.

President Penrod admitted Exhibit 1 and 4 admitted into record.

Mr. Edwards presented Exhibit 1 and 4, documentation that All City Pharmacy was properly served.

Board Action:

Motion: Jade Jacobo moved that Board Staff properly served All City Pharmacy based on the exhibits presented.

Second: Melissa Shake

Action: Passed unanimously

Board Action:

Motion: Kevin Desmond moved to find All City Pharmacy guilty of the Third Cause of Action.

Second: Robert Sullivan

Action: Passed unanimously

Board discussion ensued regarding potential penalties for All City Pharmacy.

Board Action:

Motion: Melissa Shake moved that All City Pharmacy shall pay a $5,000 fine and $1,250 administrative fee. All City Pharmacy shall have up to quarterly inspections for one year at the company's expense.

Second: Jade Jacobo

Action: Passed unanimously

C. Candy C. Davis, R.Ph (17-086-RPH-S)
D. Walgreens Pharmacy #4579 (17-086-PH-A-S)
E. Walgreens Pharmacy #2445 (17-086-PH-A-S)

Melissa Shake recused from participation in this matter due to her employment with Walgreen's Pharmacy.

Candy Davis and Kalin Pascacio-Bayles, pharmaceutical technician, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Bill Stilling was present as counsel representing the Respondents.

Mr. Kandt summarized the facts of the case where patient J.M. received the wrong medication. During data entry, Ms. Pascacio-Bayles mistakenly selected Risperidone 2mg. rather than Ropinrole 2 mg. tables as prescribed. Ms. Davis failed to detect the error at data entry verification. J.M. subsequently obtained three refills of this prescription. Each automatic refill was filled by pharmacists in Florida at Walgreens Mail Service's facility. The three pharmacists in Florida failed to detect the error. J.M. ingested 103 tablets of the wrong medication before Walgreens discovered the error.

Mr. Kandt presented a Stipulation and Order regarding the Respondents.

Ms. Davis shall receive a Letter of Reprimand, shall pay a $1,000 fine and a $1,000 administrative fee. Ms. Davis shall complete an additional 2 CEU on error prevention.

Walgreens Pharmacy #4579 shall pay a $1,000 fine and a $1,000 administrative fee.

Walgreens Pharmacy #2445 shall pay a $2,000 and a $1,000 administrative fee.

Mr. Stilling had no objections.

Ms. Davis and Ms. Pascacio-Bayles apologized to the Board for their errors.

Board Action:

Motion: Kevin Desmond moved to accept the Stipulation and Order as presented by Board Staff.

Second: Jade Jacobo

Action: Passed unanimously

F. Wayne Mitchell, R.Ph (18-041-RPH-N)
G. Carson Tahoe Regional Medical Center (18-041-PH-N)

Wayne Mitchell appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Ann Dahl and John Cotton were present as counsel representing the Respondents.

Each Board member individually stated that they would be able to participate in this matter fairly and without bias.

Mr. Edwards summarized the facts of this case where in February 2018 an anesthesiologist administered to patient L.S. an epidural containing bupivacaine with methylparaben, instead of the preservative-free bupivacaine required for an epidural. The discovery and investigation of this error revealed that Carson Tahoe Regional Medical Center either did not have written policies and procedures in place to adequately record its epidural compounding processes and prevent errors, or the pharmacy had written policies that it did not follow.

Mr. Edwards presented a Stipulation and Order regarding Mr. Mitchell and Carson Tahoe Regional Medical Center.

Mr. Mitchell shall receive a Letter of Reprimand and shall pay a $500 fine and $500 administrative fee.

Carson Tahoe Regional Medical Center shall pay a $1,000 fine and $2,500 administrative fee. Carson Tahoe Regional Medical Center shall purchase new software to properly track the components used in its compounding services and the products it compounds. Carson Tahoe shall train its staff on how to use the new software and shall create new policies and procedures regarding medication management, compounding, and the use of new software.

Mr. Mitchell stated that the new software has been purchased, and described for the Board how it better tracks the components used in compounding and the staff participating in compounding.

Board Action:

Motion: Jade Jacobo moved to accept the Stipulation and Order as presented.

Second: Melissa Shake

Action: Passed unanimously

H. Kara Balduzzi, R.Ph (18-071-RPH-S)
I. Walgreens Pharmacy #15035 (18-071-PH-S)

Melissa Shake recused from participation in this matter due to her employment with Walgreens.

Kara Balduzzi appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Bill Stilling was present as counsel representing Ms. Balduzzi and Walgreens Pharmacy.

Mr. Edwards summarized the facts of the case where Ms. Balduzzi incorrectly selected prednisone 50 mg. tablets instead of the prednisone 5 mg. tablets as prescribed. Ms. Balduzzi failed to detect the error during data entry review, she overrode 3 drug utilization review warnings, and failed again to detect the error during final product verification.

Mr. Edwards presented a Stipulation and Order regarding the Respondents.

Ms. Balduzzi shall pay a total fine of $1,000 and a $500 administrative fee. She shall complete an additional 2 CEUs on prescription verification and error prevention and 2 CEUs on drug utilization review warnings.

Walgreens Pharmacy shall pay a $1,000 administrative fee within 60 days.

Mr. Stilling had no objection.

Ms. Balduzzi apologized to the patient, the prescriber and the Board for her error.

Board Action:

Motion: Kevin Desmond moved to accept the Stipulation and Order with an amendment to have Ms. Balduzzi's CEUs due within 60 days.

Second: Jade Jacobo

Action: Passed unanimously

J. Josielyn Sy, R.Ph (18-092-RPH-N)
K. Walmart Pharmacy #10-2106 (18-092-PH-N)

President Penrod recused from participation in this matter due to his employment with Walmart.

Jade Jacobo recused from participation in this matter due to her employment with Walmart.

Kevin Desmond acted as Board President during this matter.

Josielyn Sy and Debbie Mack appeared and were sworn by Acting President Desmond prior to answering questions or offering testimony.

Susan Trujillo and Lynn Beggs were present as counsel representing Ms. Sy and Walmart Pharmacy.

Mr. Kandt summarized the facts of the case where Ms. Sy failed to detect a prescription error during data entry verification. On August 6, 2018, patient C.G. saw her dentist who prescribed 30 Amoxicillin 500 mg capsules. Pharmaceutical technician Robert White performed data entry. Mr. White mistakenly entered the instructions as "take 2 capsules by mouth now then every 6 hours until gone", rather than take 2 capsules now, then 1 capsule every six hours until gone, as prescribed

Mr. Kandt presented a Stipulation and Order regarding the Respondents.

Ms. Sy shall receive a Letter of Reprimand, shall pay a $1,000 fine and a $1,000 administrative fee. Ms. Sy shall complete 2 additional CEU on error prevention within 60 days.

Walmart Pharmacy shall pay a $1,000 fine and a $1,000 administrative fee.

Ms. Sy apologized to the Board and to her patient for her error. Ms. Sy described the changes she has made in her practice to prevent this error in the future.

Board Action:

Motion: Gener Tejero moved to accept the Stipulation and Order as presented.

Second: Melissa Shake

Action: Passed unanimously

L. Sean Barclay, R.Ph (19-002-RPH-S)
M. Meta Pharmacy (19-002-PH-S

Sean Barclay appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Edwards stated that Mr. Barclay has appeared before the Board before requesting Board approval to renew his pharmacist registration.

Mr. Edwards summarized the facts of the case that Mr. Barclay had failed to renew his pharmacist registration and had worked approximately 224 days without a registration.

Mr. Barclay apologized to the Board for his error. He stated that he does not dispute the facts as summarized by Mr. Edwards. Mr. Barclay stated he feels this appearance is duplicative of his previous appearance.

Mr. Edwards moved to have Exhibit 1 admitted into the record.

Mr. Barclay had no objection.

Mr. Edwards presented Exhibit 1, an email from Mr. Barclay to Board Staff.

President Penrod admitted Exhibit 1 into the record.

Board Action:

Motion: Melissa Shake moved that the factual allegations in the Notice of Intended Action and Accusation are true.

Second: Kevin Desmond

Action: Passed unanimously

Board Action:

Motion: Jade Jacobo moved to find Sean Barclay guilty of the First through Third Causes of Action.

Second: Melissa Shake

Action: Passed unanimously

Mr. Edwards moved to have Exhibit 2 admitted into the record.

President Penrod admitted Exhibit 2 into the record.

Mr. Edwards presented Exhibit 2, documentation of expenses accrued during the investigation and preparation of this case.

Board Action:

Motion: Jade Jacobo moved that the fees presented by Board Staff are fair, reasonable, actual and necessarily incurred.

Second: Kevin Desmond

Action: Passed unanimously

Board discussion ensued regarding potential penalties for Mr. Barclay.

Board Action:

Motion: Melissa Shake moved to find that Sean Barclay shall pay a $2,500 fine and a $1,000 administrative fee. Meta Pharmacy shall pay a $5,000 fine and a $2693.99 administrative fee. Board Staff is authorized to approve a payment plan if necessary.

Second: Kevin Desmond

Action: Passed unanimously

N. Melina Cruz, PT (19-019-PT-S)

Jade Jacobo disclosed that she has supervised Melina Cruz, but stated that she could participate in this matter fairly and without bias.

Melina Cruz appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Kandt stated that Ms. Cruz did not submit an Answer or Notice of Defense.

Mr. Kandt summarized the facts of the case where Ms. Cruz was terminated from her employment as a pharmaceutical technician at CVS Pharmacy #08803 for diversion of controlled substances. Ms. Cruz admitted to diverting approximately 2 Alprazolam 1 mg. tablets from CVS for self-use.

Ms. Cruz apologized to the Board for her error. She explained that she is currently in therapy and hopes to someday be able to be a pharmacist in the future.

Mr. Kandt moved to have Exhibit 1 admitted into the record.

Ms. Cruz had no objections.

President Penrod admitted Exhibit 1 into the record.

Mr. Kandt presented Exhibit 1. Exhibit 1 was a report of theft, a DEA Form 106, and statements from Ms. Cruz and a CVS investigator.

Board Action:

Motion: Melissa Shake moved to that the factual allegations in the Notice of Intended Action and Accusation are true.

Second: Robert Sullivan

Action: Passed unanimously

Board Action:

Motion: Melissa Shake moved to find Melina Cruz guilty of the First through Fourth Causes of Action based on the evidence and testimony provided.

Second: Jade Jacobo

Action: Passed unanimously

Mr. Kandt stated that Board Staff recommends revocation of Ms. Cruz's Pharmaceutical Technician Registration.

Board Action:

Motion: Kevin Desmond moved to revoke Melina Cruz's Pharmaceutical Technician Registration for a minimum of 1 year.

Second: Robert Sullivan

Action: Passed unanimously

5. Applications for Out-of-State Pharmacy – Appearance

A. Avasa Rx Pharmacy – Phoenix, AZ

Ed Sotherden, Vice President of Market Access and Hematology, and Ronak Modi, managing pharmacist, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Joe Dodge, Inspector Nevada State Board of Pharmacy, appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Sotherden presented a Letter of Authorization allowing him to speak on behalf of the company.

Mr. Modi testified that Avasa Rx Pharmacy does not perform sterile compounding at this facility.

Mr. Modi and Mr. Sotherden answered questions to the Board's satisfaction regarding Avasa Rx Pharmacy's products and services provided, policies and procedures, staff training, software and marketing.

Board Action:

Motion: Jade Jacobo moved to approve Avasa Rx Pharmacy's Application for Out-of-State Pharmacy License.

Second: Wayne Mitchell

Action: Passed unanimously

B. One Choice Pharmacy – Stafford, TX

This matter was postponed to a future meeting at the applicant's request.

C. Soleo Health Inc. – Woodridge, IL

Jason Howard, Director of Specialty Pharmacy, appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Howard presented a Letter of Authorization allowing him to speak on behalf of the company.

Mr. Howard answered questions to the Board's satisfaction regarding Soleo Health Inc.'s products and services provided, staff, marketing, shipping procedures and Soleo Health Inc.'s past discipline in other states.

Board Action:

Motion: Melissa Shake moved to approve Soleo Health Inc.'s Application for Out-of-State Pharmacy License.

Second: Jade Jacobo

Action: Passed unanimously

6. Applications for Nevada Pharmacy – Appearance

A. BAM Healthcare LVIC LLC – Las Vegas, NV

Robin Widroff, operations manager, and Ben Welwart, consultant, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Gener Tejero disclosed that he has a business relationship with Mr. Welwart, but stated that he could participate in this matter fairly and without bias.

Joe Dodge, Inspector Nevada State Board of Pharmacy, appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Dodge questioned Ms. Widroff and Mr. Welwart regarding BAM Healthcare LVIC LLC's, business model, products and services provided, pharmacy layout and patient counseling.

Mr. Welwart stated that BAM Healthcare does not compound any medications at this location. Mr. Welwart answered questions to the Board's satisfaction.

After discussion, the Board expressed concern regarding Ms. Widroff's and Mr. Welwart's lack of familiarity with Nevada law, and if the layout of the pharmacy is compliant with Nevada law.

Board Action:

Motion: Kevin Desmond moved to approve BAM Healthcare LVIC, LLC.'s Application for Nevada Pharmacy pending a positive inspection, BAM Healthcare LVIC, LLC. may have up to quarterly inspections at Board Staff's discretion. The inspections will be at the company's expense.

Second: Melissa Shake

Action: Passed unanimously

B. Eastside Pharmacy – Las Vegas, NV

This matter was postponed to a future meeting at the applicant's request.

C. Modern Rx - Las Vegas, NV

Melissa Shake disclosed that the managing pharmacist's wife is a Walgreens employee, but stated that she could participate in this matter fairly and without bias.

Aimee Brown, owner, Joseph Steidle, managing pharmacist, Christopher Rath, attorney, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Mr. Steidle explained that Modern Rx is an independent retail pharmacy that will also specialize in CPAP equipment.

The Board questioned Ms. Brown and Mr. Steidle regarding the pharmacy's products provided, Mr. Steidle's pharmacy experience and past discipline, Ms. Brown's work history and the pharmacy's business hours.

Mr. Rath explained that Mr. Nguyen was listed as the managing pharmacist on the application. He explained that an updated application was submitted to Board Staff by email.

Ms. Brown and Mr. Steidle answered questions to the Board's satisfaction.

Board Action:

Motion: Kevin Desmond moved to approve Modern Rx's Application for Nevada Pharmacy License pending a positive inspection and review of Modern Rx's updated application.

Second: Jade Jacobo

Action: Passed unanimously

7. Application for Nevada Medical, Devices, Equipment and Gases – Appearance

USOC Equipment, LLC – Las Vegas, NV

Duane Gilmore, Vice President of Operations, appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Gilmore explained that USOC Equipment, LLC provides primarily patient monitoring equipment and infusion pumps.

Mr. Gilmore answered questions to the Board's satisfaction regarding the products and services provided, business ownership structure, and his work experience.

Board Action:

Motion: Jade Jacobo moved to approve USOC Equipment, LLC.'s Application for Nevada MDEG License pending a positive inspection.

Second: Kevin Desmond

Action: Passed unanimously

Public Comment April 10, 2019 3:30 PM

There was no public comment.

8. Request for Pharmacist Registration by Score Transfer – Appearance

Kurt A. Howe

Kurt Howe appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Kandt stated that Mr. Howe disclosed on his application a history of diverting hydrocodone and filling his prescription for Vyvanse before it was due.

Mr. Howe apologized to the Board for his error.

Mr. Howe explained that after the revocation of his license he enrolled into a Recovering Professionals Program.

Mr. Howe answered questions regarding his recovery, current employment, past discipline and education.

Board discussion ensued regarding Mr. Howe being evaluated by PRN-PRN.

President Penrod offered Mr. Howe the option to table his application while he is evaluated by PRN-PRN and to provide Board Staff with documentation on his discipline in other states.

The Board tabled Mr. Howe's Application for Nevada Pharmacist Registration at his request.

9. Requests for Controlled Substance Registration – Appearance

A. Jorge Y. Burgos, MD

This matter was continued to a future meeting.

B. Mehran Salek, MD

Mehran Salek appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Maria Nutile was present as counsel representing Dr. Salek.

Ms. Nutile provided a summary of Dr. Salek's past discipline and his work history since 2004.

Dr. Salek answered questions to the Board's satisfaction.

After discussion, the Board expressed concern regarding Dr. Salek's knowledge of recent law changes regarding controlled substances in Nevada.

Board Action:

Motion: Wayne Mitchell moved to approve Mehran Salek's Application for Controlled Substance Registration with the condition that Dr. Salek meets with Board Staff to discuss Nevada Law regarding prescribing controlled substances

Second: Melissa Shake

Action: Passed unanimously

C. David J. Smith, MD

This matter was continued to a future meeting at Dr. Smith's request.

10. Request for Controlled Substance Renewal – Appearance

A. Markey Wilson, PA

Markey Wilson appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Wuest provided background information. He explained that Ms. Wilson did not renew her controlled substance registration and prescribed medication while her registration was

expired. Mr. Wuest explained that Ms. Wilson agreed to a verbal cease and desist. Due to the timing that this issue was discovered, she did not receive the 21 day notice to appear.

Ms. Wilson verbally waived her right to 21 day notice.

Ms. Wilson explained to the Board the circumstances that led to not renewing her controlled substance registration. Ms. Wilson apologized to the Board and claimed responsibility for her actions.

Mr. Wuest explained that Ms. Wilson will reappear before the Board for a disciplinary hearing on this matter.

Board Action:

Motion: Jade Jacobo moved to approve Markey Wilson's Request for Controlled Substance Registration Renewal.

Second: Melissa Shake

Action: Passed unanimously

B. Roger Estevez, MD

Roger Estevez appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Wuest explained that Dr. Estevez appeared the Board before regarding his practitioner dispensing registration. He stated that Dr. Estevez failed to renew his controlled substance registration and had prescribed controlled substances while his license was expired.

Mr. Kandt explained that due to the timing this issue was discovered Dr. Estevez did not receive the written 21 day notice to appear.

Dr. Estevez verbally waived his right to 21 day notice.

Dr. Estevez agreed with Mr. Wuest's summary of events.

The Board questioned Dr. Estevez regarding how this error occurred and how to prevent this error in the future.

Mr. Kandt stated that Dr. Estevez will reappear before the Board for a disciplinary hearing on this matter.

Board Action:

Motion: Kevin Desmond moved to approve Roger Estevez's Request for Controlled Substance Registration Renewal.

Second: Melissa Shake

Action: Passed unanimously

11. Request to Amend Conditions of Reinstatement of Pharmacist Registration to Remove Prohibition from Working as a Managing Pharmacist

Ashley Isom (15-074-RPH-N)

Ashley Isom and Larry Espadero, Director PRN-PRN, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Ms. Isom explained that she is requesting the Board amend the conditions of her reinstatement to allow her to act as managing pharmacist.

Mr. Espadero summarized Ms. Isom's recovery and spoke positively of her progress.

Ms. Isom answered questions to the Board's satisfaction regarding her past discipline, addiction and recovery.

Mr. Espadero recommended Ms. Isom be allowed to act as a managing pharmacist with conditions to increase her PRN-PRN contract for an additional year and to maintain her 90 hour per 2 week work limitation.

Board Action:

Motion: Wayne Mitchell moved to allow Ashley Isom to work as a managing pharmacist with conditions that she renew her contract with PRN-PRN for an additional year and that she comply with all conditions of her PRN-PRN contract.

Second: Kevin Desmond

Action: Passed unanimously

12. Request for Reinstatement of Revoked Pharmacist License: - Appearance

Jose Ferran (17-039-RPH-S)

Jade Jacobo recused from participation in this matter due to her professional relationship with Mr. Ferran.

Jose Ferran appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Kevin Murphy was present as counsel for Mr. Ferran.

Mr. Kandt summarized the facts of the case where Mr. Ferran's pharmacist registration was revoked because while working as a managing pharmacist Mr. Ferran fraudulently created a total of 44 unauthorized prescriptions for himself, his family and family members of his staff.

Mr. Ferran claimed responsibility for his actions and apologized to the Board for his error.

Mr. Murphy provided a summary of Mr. Ferran's current work employment and CEU he has completed during his revocation.

Board discussion ensued regarding reinstating Mr. Ferran's pharmacist registration with conditions.

Board Action:

Motion: Melissa shake moved to approve Jose Ferran's request for reinstatement of revoked pharmacist license with conditions. Mr. Ferran's registration shall be placed on probation for two years. Mr. Ferran must notify any employer of his past discipline. Mr. Ferran shall not be a managing pharmacist, shall not compound for one year and shall not work more than 90 hours in two weeks. Mr. Ferran shall pay restitution to Walmart within 90 days, and upon getting a job the managing pharmacist shall submit quarterly reports to Board Staff regarding Mr. Ferran's performance.

Second: Kevin Desmond

Action: Passed unanimously

13. Applications for Nevada Wholesaler – Appearance

A. FENWAL, INC. – North Las Vegas, NV

Steve Shaw, operations manager, Christina Dempsey, Senior Manager of Supply Chain Solutions, Randy Topolinski, supervisor, Brian Kunz, Senior Director of Supply Chain Solutions, Craig Elkins, Senior Corporate Counsel, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Mr. Elkin's explained that FENWAL, INC. and FRESENIUS KABI, LLC. share the same corporate ownership.

Mr. Shaw, Ms. Dempsey, Mr. Topolinski, Mr. Kunz and Mr. Elkins answered questions to the Board's satisfaction regarding the products and services provided, ownership structure and staff.

Mr. Dodge described his visit to FENWAL, INC.'s facility and summarized DEA's report of their visit to the facility.

Board Action:

Motion: Kevin Desmond moved to approve FENWAL, INC.'s Application for Nevada Wholesaler License pending a positive inspection and receipt of a Letter of Authorization allowing Mr. Shaw, Ms. Dempsey, Mr. Topolinski, Mr. Kunz and Mr. Elkins to speak on behalf of the company.

Second: Robert Sullivan

Action: Passed unanimously

B. FRESENIUS KABI, LLC – North Las Vegas, NV

Steve Shaw, Christina Dempsey, Randy Topolinski, Brian Kunz, and Craig Elkins appeared on behalf of FRESENIUS KABI, LLC.

Mr. Elkins answered questions regarding FRESENIUS KABI, LLC.'S past discipline to the Board's satisfaction.

Board Action:

Motion: Jade Jacobo moved to approve FRESENIUS KABI, LLC.'S Application for Nevada Wholesaler License.

Second: Kevin Desmond

Action: Passed unanimously

14. Applications for Out-of-State Compounding Pharmacy – Appearance

A. Cure Stat Rx Home Infusion and Specialty Pharmacy, Inc. – San Diego, CA

Ramesh Chigurupati, managing pharmacist and owner, appeared and were sworn by President Penrod prior to answering questions or offering testimony.

Mr. Dodge questioned Mr. Chigurupati regarding the pharmacy's clean room specifications, staff training, pharmacy policies and procedures, product testing and past inspections.

Mr. Chigurupati answered questions to the Board's satisfaction.

The Board removed Cure Stat Rx Home Infusion and Specialty Pharmacy, Inc.'s affidavit to ship sterile products and Mr. Chigurupati's request.

Board Action:

Motion: Melissa Shake moved to approve Cure Stat Rx Home Infusion and Specialty Pharmacy, Inc.'s Application for Out-of-State Compounding Pharmacy pending receipt and review of the company's most recent inspections by the California Board of Pharmacy and ACHC. Board Staff is authorized to review the inspection reports. Cure Stat Rx Home Infusion and Specialty Pharmacy, Inc.

shall request Board approval before shipping any high risk sterile compounded products into Nevada.

Second: Gener Tejero

Action: Passed unanimously

B. MedRx Infusion Clinical Pharmacy – Inglewood, CA

Eun-Kyong Kim, pharmacist, and Simon Javaheri, CEO and CFO, appeared and were sworn by President Penrod prior to answering questions or offering testimony.
Mr. Dodge questioned Mr. Kim and Mr. Javaheri regarding MedRx Infusion Clinical Pharmacy's products and services provided, clean room specifications, beyond use dating policies, shipping policies, product testing, past inspections and the company's past discipline.

Mr. Dodge requested a copy of MedRx Infusion Clinical Pharmacy's last inspection report from the California Board of Pharmacy as well a copy of their citation from California.

Mr. Kim and Mr. Javaheri answered questions to the Board's satisfaction.

The Board removed MedRx Infusion Clinical Pharmacy's affidavit to ship sterile products and Mr. Kim's request.

Board Action:

Motion: Kevin Desmond moved to approve MedRx Infusion Clinical Pharmacy's Application for Out-of-State Compounding Pharmacy License pending receipt and review of the pharmacy's most recent inspection by the California Board of Pharmacy and a copy of the pharmacy's citation from the California Board of Pharmacy. Board Staff is authorized to evaluate the inspection report and citation.

Second: Melissa Shake

Action: Passed unanimously

C. Vasco Rx – Phoenix, AZ

Paul Vasiliauskas, COO, appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Dodge questioned Mr. Vasiliauskas regarding Vasco Rx's products and services provided, policies and procedures and past FDA inspections.

Mr. Vasiliauskas reviewed each observation listed by the FDA and explained how Vasco Rx resolved each issue.

After discussion, the Board requested Mr. Vasiliauskas provide a copy of the training plan created based on FDA's observations.

The Board questioned Mr. Vasiliauskas regarding his Vasco Rx's past discipline.

Mr. Vasiliauskas answered questions to the Board's satisfaction.

Board Action:

Motion: Kevin Desmond moved to approve Vasco Rx's Application for Out-of-State Compounding Pharmacy pending receipt and review of the training plan based on FDA's observations. Board Staff is authorized to review and evaluate the training plan.

Second: Melissa Shake

Action: Passed unanimously

15. Discussion of increasing fees imposed pursuant to NRS 639.170 and/or NRS 453.221 to maintain conformance with the Board's operating reserve policy.

Mr. Wuest provided background information.

Board discussion ensued regarding the current fee structure, responsibilities of the Board, and the costs incurred by Board activities.

Board Action:

Motion: Kevin Desmond moved to allow the Executive Secretary to pursue increasing fees to address the financial shortfalls in the Board's budget.

Second: Jade Jacobo

Action: Pass unanimously

16. General Counsel Report

17. Executive Secretary Report:

A. Financial Report

Mr. Wuest presented the financial report to the Board's satisfaction.

B. Temporary Licenses
C. Staff Activities:
   1. Meetings with Other Health Care Boards
   2. Legislature in Session
   3. NASCSA Board of Directors

4. Roseman Student Rotation – Grace Field has finished her rotation
5. MPJE Test Writing Seminar

D. Report to Board:
1. Licensing software update

E. Board Related News:
1. Upcoming NABP National Meeting

F. Licensing Activities Report:
1. PMP Integration
2. Legislative update

Public Comment April 11, 2019 9:00 AM

There was no public comment.

18. Notice of Proposed Regulation Workshop Pursuant to NRS 233B.061(2)

The purpose of the workshop is to solicit comments from interested persons on the following general topic that may be addressed in the proposed regulation:

A. Amendment of Nevada Administrative Code (NAC) 639.NEW LANGUAGE Costs for inspection.

1. In addition to any application fees paid, the Board may require an applicant to pay inspection costs incurred by the Board.

2. The Board may require an out-of-state licensee to pay inspection costs incurred by the Board.

Mr. Wuest provided background information.

President Penrod opened the Public Comment.

There was no public comment.

Board Action:

Motion: Kevin Desmond moved to adopt the proposed amendments and move forward to Public Hearing.

Second: Melissa Shake

Action: Passed unanimously

B. Amendment of Nevada Administrative Code (NAC) 639.250: Restrictions on supervision. The proposed amendment to NAC 639.250 will allow for an increase in pharmaceutical technician to pharmacist ratio in certain pharmacy settings

Mr. Edwards and Mr. Wuest provided background information.

President Penrod opened the Public Comment.

Liz MacMenamin, RAN, appeared and expressed concern on behalf of her members regarding having all personnel in a pharmacy licensed.

Lauren Paul, CVS Health, appeared and expressed concern regarding language that no person working in a pharmacy may have access to or come into contact with any controlled substance, dangerous drug or private health information unless that person is registered with the Board.

David Vasenden, pharmacist, appeared and requested the Board to increase the pharmaceutical technician to pharmacist ratio to above 5:1.

Lorrie Walmsley, Walgreens, appeared and discussed how the proposed language affects pharmacy practices where billing technicians are on staff.

Board discussion ensued regarding clarifying the language regarding pharmacy clerks, different pharmacy business models and the managing pharmacist's role in determining the correct ratio.

Board Action:

Motion: Melissa Shake moved to bring this matter back to Workshop with amendments as discussed and to increase the ratio to 8:1.

Second: Jade Jacobo

Aye: Jacobo, Mitchell, Shake, Sullivan
Nay: Desmond, Tejero

Action: Motion carries

19. Request to Engage in the Practice of Pharmacy at a Site Other Than a Licensed Pharmacy – Appearance:

Leslie Baker, R.Ph

Leslie Baker appeared and was sworn by President Penrod prior to answering questions or offering testimony.

Mr. Wuest provided background information.

Ms. Baker explained that she previously worked at Campus Pharmacy. Campus Pharmacy is closing and Ms. Baker was offered the opportunity to work at the geriatric clinic at the University of Nevada and provide MTM services.

Ms. Baker answered questions to the Board's satisfaction.

Board Action:

Motion: Kevin Desmond moved to approve Leslie Baker's request to engage in the practice of pharmacy at a site other than a licensed pharmacy.

Second: Robert Sullivan

Action: Passed unanimously

20. Date and Location of Next Scheduled Board Meeting:

June 5-6, 2019 – Reno, Nevada

21. Public Comment April 11, 2019 :00 PM

There was no public comment.

3

3/20

A

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Alto Pharmacy

Physical Address: 1400 Tennessee Street, Unit 2, San Francisco, CA, 94107

Mailing Address: 1400 Tennessee Street, Unit 2

City: San Francisco State: CA Zip Code: 94107

Telephone: (800) 874-5881 Fax: (415) 484-7780

Toll Free Number: (800) 874-5881 (Required per NAC 639.708)

E-mail: compliance@scriptdash.com Website: www.alto.com

Managing Pharmacist: Michael Lai License Number: 68183

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☑	☐ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: ____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: ____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

41 B

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☒ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: America's Pharmacy Source

Physical Address: 947 Waterloo Road, Akron, Ohio 44314

Mailing Address: 947 Waterloo Road

City: Akron State: OH Zip Code: 44314

Telephone: 833-277-6337 Fax: 330-230-8407

Toll Free Number: 833-277-6337 (Required per NAC 639.708)

E-mail: sgregor@myapsrx.com Website: www.americaspharmacysource.com

Managing Pharmacist: Joseph Chimienti License Number: Ohio #03337895

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☒	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☒	☐ Other: Mail-Order	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

411

C

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☐ *New Pharmacy* or ☑ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** 03003

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: ARx Patient Solutions Pharmacy

Physical Address: 4500 W. 107th St

Mailing Address: Same as physical address

City: Overland Park State: KS Zip Code: 66207-4025

Telephone: 866-930-4146 Fax: 866-930-4147

Toll Free Number: 866-930-4146 (Required per NAC 639.708)

E-mail: susan.smith@assistrx.com Website: N/A

Managing Pharmacist: Susan Smith License Number: KS 1-10873

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐ ☑	Retail	☐ ☑	Off-site Cognitive Services
☐ ☑	Hospital (# beds ____)	☐ ☑	Parenteral **
☐ ☑	Internet	☐ ☑	Parenteral (outpatient)
☐ ☑	Nuclear	☐ ☑	Outpatient/Discharge
☐ ☑	Ambulatory Surgery Center	☑ ☐	Mail Service
☐ ☑	Community	☐ ☑	Long Term Care
☑ ☐	Other: Out-of-State	☐ ☑	Sterile Compounding **
		☐ ☑	Non Sterile Compounding
All boxes must be checked		☐ ☑	Mail Service Sterile Compounding **
For the application to be complete		☐ ☑	Other Services:

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

D

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: COMMUNITY SPECIALTY PHARMACY, LLC

Physical Address: 6308 BENJAMIN RD SUITE 709

Mailing Address: 6308 BENJAMIN RD SUITE 709

City: Tampa State: FL Zip Code: 33634

Telephone: 727-896-0001 Fax: 727-896-0002

Toll Free Number: 844-277-4276 (Required per NAC 639.708)

E-mail: app.comsprx@gmail.com Website: www.comsprx.com

Managing Pharmacist: Nikul R Panchal License Number: PS35632

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☒	☐ Mail Service
☒	☐ Community	☒	☐ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

E

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: COLUMBUS PHARMACY

Physical Address: 246 LINCOLN CIRCLE STE B

Mailing Address: 246 LINCOLN CIRCLE STE B

City: GAHANNA State: OH Zip Code: 43230

Telephone: 614-371-6843 Fax: 614-737-9883

Toll Free Number: 844-287-5003 (Required per NAC 639.708)

E-mail: COLUMBUSPHARMACY1@GMAIL.COM Website: N/A

Managing Pharmacist: KATHERINE FINCK License Number: 03233112

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☒	☐ Mail Service
☒	☐ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

F

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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*☑ New Pharmacy or ☐ **Ownership Change** (Provide current license number if making changes: **PH**____*
Check box below for type of ownership and complete all required forms.
☐ Publicly Traded Corporation – Pages 1,2,3,7 *☐ Partnership - Pages 1,2,5,7*
☑ Non Publicly Traded Corporation – Pages 1,2,4,7 *☐ Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Caremark Tennessee Specialty Pharmacy, LLC dba CVS/specialty #48050

Physical Address: 8370 Wolf Lake Dr, Ste 107, Bartlett, TN 38133

Mailing Address: One CVS Drive, Licensing Dept/MC 1160, Woonsocket, RI 02895

City: Bartlett State: TN Zip Code: 38133

Telephone: 901-385-4100 Fax: 901-385-4155

Toll Free Number: 800-318-6108 (Required per NAC 639.708)

E-mail: PermitInfo@CVSHealth.com Website: _____

Managing Pharmacist: Rose Blake License Number: 770+

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	Retail	☐	Off-site Cognitive Services
☐	Hospital (# beds ____)	☐	Parenteral **
☐	Internet	☐	Parenteral (outpatient)
☐	Nuclear	☐	Outpatient/Discharge
☐	Ambulatory Surgery Center	☑	Mail Service
☐	Community	☐	Long Term Care
☑	Other: mail order	☐	Sterile Compounding **
		☐	Non Sterile Compounding
	All boxes must be checked	☐	Mail Service Sterile Compounding **
	For the application to be complete	☐	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

G

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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☐ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☒ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: DCE PHARMACY

Physical Address: 2540 FM 2920, SUITE G SPRING TX 77388

Mailing Address: 2540 FM 2920, SUITE G SPRING TX 77388

City: SPRING State: TX Zip Code: 77388

Telephone: 281-528-0288 Fax: 832-558-1028

Toll Free Number: 866-802-8826 (Required per NAC 639.708)

E-mail: PHARMACY2@DCEPHARMACY.COM Website: N/A

Managing Pharmacist: GLENN AMAKWE License Number: 57455

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☒	☑ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

4/1
H

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Deliver My Meds Corp.

Physical Address: 380 Oser Ave. Hauppauge N.Y. 11788

Mailing Address: 380 Oser Ave. Hauppauge N.Y. 11788

City: Hauppauge State: N.Y. Zip Code: 11788

Telephone: (631) 323-6337 Fax: (833) 329-6979

Toll Free Number: (833) 323-6337 (Required per NAC 639.708)

E-mail: Hello@delivermymeds.com Website: www.delivermymeds.com

Managing Pharmacist: Sophia Chaudhary License Number: 061430

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

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I

NEVADA STATE BOARD OF PHARMACY

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☐ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☒ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: DeseRt Rx PHARMACY

Physical Address: 73091 Country Club Drive

Mailing Address: Suite A4

City: Palm City State: CA Zip Code: 92260

Telephone: 760-836-3738 Fax: 866 848-1514

Toll Free Number: 866-345-8447 (Required per NAC 639.708)

E-mail: Compliance.pharmacy@gmail.com Website: NA

Managing Pharmacist: Rosanna Hohzhausen License Number: RPH 54413

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	Retail	☐	Off-site Cognitive Services
☐	Hospital (# beds ____)	☐	Parenteral **
☐	Internet	☐	Parenteral (outpatient)
☐	Nuclear	☐	Outpatient/Discharge
☐	Ambulatory Surgery Center	☒	Mail Service
☑	Community	☐	Long Term Care
☐	Other: N/A	☐	Sterile Compounding **
		☐	Non Sterile Compounding
	All boxes must be checked	☐	Mail Service Sterile Compounding **
	For the application to be complete	☐	Other Services: NA

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

J

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7* ☐ *Partnership - Pages 1,2,5,7*

☑ *Non Publicly Traded Corporation – Pages 1,2,4,7* ☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Discount Plus Pharmacy

Physical Address: 7125 W. Fuqua Missouri City TX 77489

Mailing Address: 7125 W. Fuqua Missouri City, TX 77489

City: Missouri City State: TX Zip Code: 77489.

Telephone: 281-272-6165 Fax: 832-672-8792

Toll Free Number: 877-521-1590 (Required per NAC 639.708)

E-mail: credentialing@discountplusphamacy.com Website: N/A

Managing Pharmacist: Jonathan Lekuuo License Number: 35206

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑ ☐	Retail	☐ ☑	Off-site Cognitive Services
☐ ☑	Hospital (# beds ____)	☐ ☑	Parenteral **
☐ ☑	Internet	☐ ☑	Parenteral (outpatient)
☐ ☑	Nuclear	☐ ☑	Outpatient/Discharge
☐ ☑	Ambulatory Surgery Center	☑ ☐	Mail Service
☐ ☑	Community	☐ ☑	Long Term Care
☐ ☑	Other: _____	☐ ☑	Sterile Compounding **
		☐ ☑	Non Sterile Compounding
	All boxes must be checked	☐ ☑	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☑	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

3/20

K

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☑ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: FREEDOM PHARMACY, LLC

Physical Address: 7339 AIRPORT FRWY

Mailing Address: 7339 AIRPORT FRWY

City: RICHLAND HILLS State: Texas Zip Code: 76118

Telephone: 817-590-8339 Fax: 817-590-9431

Toll Free Number: 833-590-8339 (Required per NAC 639.708)

E-mail: cjackson@freedompharmrx.com Website: _____

Managing Pharmacist: Aaron Hirsch License Number: 52801

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☐ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☐ Internet	☐	☑ Parenteral (outpatient)
☐	☐ Nuclear	☐	☑ Outpatient/Discharge
☐	☐ Ambulatory Surgery Center	☒	☐ Mail Service
☒	☐ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

L

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☑ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH***____

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☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☑ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: GOKUL RX LLC

Physical Address: 1218 WINTER GARDEN VINELAND RD, SUITE# 112

Mailing Address: 1218 WINTER GARDEN VINELAND RD, SUITE# 112

City: WINTER GARDEN State: FLORIDA Zip Code: 34787

Telephone: (866)742-7626 Fax: (888)465-8579

Toll Free Number: (866)742-7626 (Required per NAC 639.708)

E-mail: benzerwg@gmail.com Website: N/A

Managing Pharmacist: ANKIT PATEL License Number: PS37355/ FLORIDA

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑ ☐	Retail	☐ ☑	Off-site Cognitive Services
☐ ☑	Hospital (# beds ____)	☐ ☑	Parenteral **
☐ ☑	Internet	☐ ☑	Parenteral (outpatient)
☐ ☑	Nuclear	☐ ☑	Outpatient/Discharge
☐ ☑	Ambulatory Surgery Center	☒ ☑	Mail Service
☑ ☐	Community	☐ ☑	Long Term Care
☐ ☑	Other: _____	☐ ☑	Sterile Compounding **
		☐ ☑	Non Sterile Compounding
	All boxes must be checked	☐ ☑	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☑	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

7.12

M

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Marco Island Pharmacy 2, LLC

Physical Address: 5475 Golden Gate Parkway unit 5W

Mailing Address: 5475 Golden Gate Parkway unit 5W

City: Naples State: Florida Zip Code: 34116

Telephone: 877-579-7605 Fax: 239-315-4824

Toll Free Number: 877-579-7605 (Required per NAC 639.708)

E-mail: Pharmacy@MIRX.us Website: _____

Managing Pharmacist: Mark A. Kaplan License Number: PS33342

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☑ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☐ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☐ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

N

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: PANTHERx Specialty Pharmacy

Physical Address: 1120 Stevenson Mill Road Ste 400 Coraopolis, PA 15108

Mailing Address: 24 Summit Park Dr. STE 101

City: ~~Coraopolis~~ Pittsburgh State: PA Zip Code: ~~15108~~ 15275

Telephone: 855-726-8479 Fax: 855-246-3986

Toll Free Number: 855-726-8479 (Required per NAC 639.708)

E-mail: compliance@pantherspecialty.com Website: www.PantherxSpecialty.com

Managing Pharmacist: Timothy Davis License Number: PA RP046038L

TYPE OF PHARMACY AND		SERVICES PROVIDED	
Yes/No		Yes/No	
☐ ☒	Retail	☐ ☒	Off-site Cognitive Services
☐ ☒	Hospital (# beds ____)	☐ ☒	Parenteral **
☐ ☒	Internet	☐ ☒	Parenteral (outpatient)
☐ ☒	Nuclear	☐ ☒	Outpatient/Discharge
☐ ☒	Ambulatory Surgery Center	☒ ☐	Mail Service
☐ ☒	Community	☐ ☒	Long Term Care
☒ ☐	Other: Specialty	☐ ☒	Sterile Compounding **
		☐ ☒	Non Sterile Compounding
All boxes must be checked		☐ ☒	Mail Service Sterile Compounding **
For the application to be complete		☐ ☐	Other Services: ____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

O

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Premier Pharmacy LLC

Physical Address: 53 Stiles Rd. suite B102

Mailing Address: 53 Stiles Rd. suite B102

City: Salem State: NH Zip Code: 03079

Telephone: 603·328·5134 Fax: 603·215·7034

Toll Free Number: 1·888·201·1590 (Required per NAC 639.708)

E-mail: customerservice@premier-pharmacy.net Website: _____

Managing Pharmacist: Maureen Simonds License Number: NH 2850

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☐ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☐ Other Services: _____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting.**

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Riverside Community Pharmacy, Inc

Physical Address: 1456 NW 17 Ave Miami, FL 33125

Mailing Address: 1456 NW 17 Ave Miami

City: Miami State: Florida Zip Code: 33126

Telephone: 800-268-1274 Fax: 305-549-5499

Toll Free Number: 800-268-1274 (Required per NAC 639.708)

E-mail: pharmacy@rcrx.us Website: _____

Managing Pharmacist: Maria Galarza License Number: PS57545

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☑ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

44

Q

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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☒ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** *____*
Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*	☐ *Partnership - Pages 1,2,5,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*	☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: River's Edge Specialty Pharmacy

Physical Address: 17332 Von Karman Ave., # 110 Irvine, CA 92614

Mailing Address: 17332 Von Karman Ave., # 110

City: Irvine State: CA Zip Code: 92614

Telephone: 949.393.5780 Fax: 949.393.5790

Toll Free Number: 866.412.3156 (Required per NAC 639.708)

E-mail: Signature@REPharmacy.com Website: WWW.REPHARMACY.com

Managing Pharmacist: Shurehan Salib License Number: 65914

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☒	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral **
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☒	☐ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☒	☐ Other: Specialty	☐	☒ Sterile Compounding **
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☐	☒ Mail Service Sterile Compounding **
	For the application to be complete	☐	☒ Other Services: ____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

R

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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☒ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Roman Health Pharmacy, LLC

Physical Address: 3602 Quantum Blvd Boynton Beach, FL 33426

Mailing Address: 3602 Quantum blvd

City: Boynton Beach State: Florida Zip Code: 33426

Telephone: 888-798-8686 Fax: NONE

Toll Free Number: 888-798-8686 (Required per NAC 639.708)

E-mail: christina@ro.co Website: www.getroman.com

Managing Pharmacist: Luke Caswell License Number: PS55219

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒ ☐	Retail	☐ ☒	Off-site Cognitive Services
☐ ☒	Hospital (# beds ____)	☐ ☒	Parenteral **
☒ ☐	Internet	☐ ☒	Parenteral (outpatient)
☐ ☒	Nuclear	☐ ☒	Outpatient/Discharge
☐ ☐	Ambulatory Surgery Center	☒ ☐	Mail Service
☐ ☒	Community	☐ ☒	Long Term Care
☐ ☐	Other: _____	☐ ☒	Sterile Compounding **
		☐ ☒	Non Sterile Compounding
	All boxes must be checked	☐ ☒	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☒	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

S

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☐ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: SinfoniaRx, Inc.

Physical Address: 1812 Centre Creek Drive Suite 115

Mailing Address: Same as physical

City: Austin State: TX Zip Code: 78754

Telephone: 512-579-0026 Fax: 512-579-0008

Toll Free Number: 1-855-866-3730 (Required per NAC 639.708)

E-mail: Austin-Facility_Licenses@sinfoniarx.com Website: www.sinfoniarx.com

Managing Pharmacist: Saul Ortega License Number: 61241

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	Retail	☐	Off-site Cognitive Services
☐	Hospital (# beds ____)	☐	Parenteral **
☐	Internet	☐	Parenteral (outpatient)
☐	Nuclear	☐	Outpatient/Discharge
☐	Ambulatory Surgery Center	☐	Mail Service
☐	Community	☐	Long Term Care
☒	Other: Non-Dispensing	☐	Sterile Compounding **
		☐	Non Sterile Compounding
All boxes must be checked		☐	Mail Service Sterile Compounding **
For the application to be complete		☒	Other Services: Medication Therapy Management

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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*☑ New Pharmacy or ☐ **Ownership Change** (Provide current license number if making changes: **PH**____*
Check box below for type of ownership and complete all required forms.
☐ Publicly Traded Corporation – Pages 1,2,3,7 *☐ Partnership - Pages 1,2,5,7*
☑ Non Publicly Traded Corporation – Pages 1,2,4,7 *☐ Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: SinfoniaRx, Inc.

Physical Address: 2815 NW 13th Street Suite 204

Mailing Address: Same as physical

City: Gainesville State: Florida Zip Code: 32609

Telephone: 877-654-6035 Fax: 352-204-5647

Toll Free Number: 1-855-866-3730 (Required per NAC 639.708)

E-mail: Florida-Facility_Licenses@sinfoniarx.com Website: www.sinfoniarx.com

Managing Pharmacist: Karen McLin License Number: PS 27694

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☐ Retail	☐	☐ Off-site Cognitive Services
☐	☐ Hospital (# beds ____)	☐	☐ Parenteral **
☐	☐ Internet	☐	☐ Parenteral (outpatient)
☐	☐ Nuclear	☐	☐ Outpatient/Discharge
☐	☐ Ambulatory Surgery Center	☐	☐ Mail Service
☐	☐ Community	☐	☐ Long Term Care
☒	☐ Other: Non-Dispensing	☐	☐ Sterile Compounding **
		☐	☐ Non Sterile Compounding
All boxes must be checked		☐	☐ Mail Service Sterile Compounding **
For the application to be complete		☒	☐ Other Services: Medication Therapy Management

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☒ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: VALUSTAR PHARMACY

Physical Address: 7227 FANNIN STREET, SUITE 103, HOUSTON, TX 77030

Mailing Address: BIOTEK REMEDYS 2 PENNS WAY STE 404

City: NEW CASTLE State: DE Zip Code: 19720

Telephone: 844-855-0101 Fax: 888-963-8103

Toll Free Number: 877-246-9104 (Required per NAC 639.708)

E-mail: credentialing@biotekrx.com Website: WWW.BIOTEKRX.COM

Managing Pharmacist: RAHUL RAVIPATI License Number: 61665

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☒	Retail	☐ ☒	Off-site Cognitive Services
☐ ☒	Hospital (# beds ____)	☐ ☒	Parenteral **
☐ ☒	Internet	☐ ☒	Parenteral (outpatient)
☐ ☒	Nuclear	☐ ☒	Outpatient/Discharge
☐ ☒	Ambulatory Surgery Center	☒	Mail Service
☐ ☒	Community	☐ ☒	Long Term Care
☒ ☐	Other: SPECIALTY	☐ ☒	Sterile Compounding **
		☐ ☒	Non Sterile Compounding
All boxes must be checked		☐ ☒	Mail Service Sterile Compounding **
For the application to be complete		☐ ☒	Other Services: ____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

4.15 ✓

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** *_____*
Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*	☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*	☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Your Choice Pharmacy

Physical Address: 1768 Highway 14E Landrum SC 29356

Mailing Address: 1768 Highway 14E Landrum SC 29356

City: _____ State: _____ Zip Code: _____

Telephone: 864-777-7076 Fax: 866-435-1729

Toll Free Number: 855-493-0347 (Required per NAC 639.708)

E-mail: YourChoicePharmacySC@gmail.com Website: _____

Managing Pharmacist: Joel Pressman License Number: 37388

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☑ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** _____

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☒ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Apostrophe Pharmacy

Physical Address: 201 W. Guadalupe rd Ste 202

Mailing Address: Same As Above

City: Gilbert State: Arizona Zip Code: 85233

Telephone: 480-621-8274 Fax: 480-210-8364

Toll Free Number: 844-333-6693 (Required per NAC 639.708)

E-mail: Luke@apostrophe.com Website: N/A

Managing Pharmacist: Luke Wright License Number: 5022116

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds_____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding **
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

X

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

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☑ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Integrative Pharmacy Solutions, INC d/b/a King's Pharmacy & Compounding Center

Physical Address: 16205 Sand Canyon Avenue, Suite 105 Irvine, CA 92618

Mailing Address: 16205 Sand Canyon Avenue, Suite 105 Irvine, CA 92618

City: Irvine State: CA Zip Code: 92618

Telephone: 949.387.0780 Fax: 949.387.0784

Toll Free Number: 866.921.8632 (Required per NAC 639.708)

E-mail: kingsirvine@gmail.com Website: www.drcompound.com

Managing Pharmacist: Rani Dibbini, Pharm.D. License Number: PHY58852

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☑	☐ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☐ Other: _____	☐	☑ Sterile Compounding **
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☐	☐ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

4-18

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

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☒ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** *____*
Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Skin Specialty Solutions, Inc.

Physical Address: 2058 Fenton Logistics Park, Fenton, Missouri 63026

Mailing Address: 4866 Lakebird Place

City: San Jose State: CA Zip Code: 95124

Telephone: 877-273-1777 Fax: 314-499-8171

Toll Free Number: 877-273-1777 (Required per NAC 639.708)

E-mail: lindsaypharmd@skinspecialtysolutions.com Website: Not applicable

Managing Pharmacist: Lindsay Reel, Pharmacist in Charge License Number: 2006025351 Missouri

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐ ☒	Retail	☐ ☒	Off-site Cognitive Services
☐ ☒	Hospital (# beds ____)	☐ ☒	Parenteral **
☐ ☒	Internet	☐ ☒	Parenteral (outpatient)
☐ ☒	Nuclear	☐ ☒	Outpatient/Discharge
☐ ☒	Ambulatory Surgery Center	☒ ☐	Mail Service
☐ ☒	Community	☐ ☒	Long Term Care
☐ ☐	Other: _____	☐ ☒	Sterile Compounding **
		☒ ☐	Non Sterile Compounding
	All boxes must be checked	☐ ☒	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☒	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

#11 Z

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☑ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☑ *Partnership - Pages 1,2,5,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: SNF HOLDINGS LLC

Physical Address: 25875 Novi Road Suite 130

Mailing Address: 25875 Novi Road Suite 130

City: Novi State: MI Zip Code: 48375

Telephone: 248-530-5769 Fax: 248-308-2635

Toll Free Number: 844-232-7098 (Required per NAC 639.708)

E-mail: SNFHOLDINGSLLC@gmail.com Website: _____

Managing Pharmacist: Fayez Faraj License Number: 5302031978 Michigan

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes	No	TYPE OF PHARMACY	Yes	No	SERVICES PROVIDED
☑	☐	Retail	☐	☑	Off-site Cognitive Services
☐	☑	Hospital (# beds ____)	☐	☑	Parenteral **
☐	☑	Internet	☐	☑	Parenteral (outpatient)
☐	☑	Nuclear	☐	☑	Outpatient/Discharge
☐	☑	Ambulatory Surgery Center	☑	☐	Mail Service
☑	☐	Community	☐	☑	Long Term Care
☐	☑	Other: _____	☐	☑	Sterile Compounding **
			☑	☐	Non Sterile Compounding
		All boxes must be checked	☐	☑	Mail Service Sterile Compounding **
		For the application to be complete	☐	☑	Other Services: _____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

AA

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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☒ *New Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** *____*
Check box below for type of ownership and complete all required forms.
☐ *Publicly Traded Corporation – Pages 1,2,3,7* ☐ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7* ☒ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Solara Medical Supplies

Physical Address: 2084 Otay Lakes Road, STE 102

Mailing Address: 2084 Otay Lakes Road, STE 102

City: Chula Vista State: CA Zip Code: 91913-1368

Telephone: 800-999-7516 Fax: 800-900-7021

Toll Free Number: 800-999-7516 (Required per NAC 639.708)

E-mail: compliance@solaramedicalsupplies.com Website: www.solaramedicalsupplies.com

Managing Pharmacist: John A. Williams License Number: RPH 36520

TYPE OF PHARMACY AND		SERVICES PROVIDED	
Yes/No		Yes/No	
☒	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral **
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☒	☐ Mail Service
☒	☐ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☐	☒ Sterile Compounding **
		☐	☒ Non Sterile Compounding
All boxes must be checked		☐	☒ Mail Service Sterile Compounding **
For the application to be complete		☐	☒ Other Services: _____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

BB

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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☑ *New Pharmacy or* ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH***____

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: ZIPHEALTH INC

Physical Address: 140 Jupiter Lakes Blvd # B , Jupiter , FL , 33458

Mailing Address: 140 Jupiter Lakes Blvd # B ,

City: Jupiter , State: FL , Zip Code: 33458

Telephone: 305-425-9280 Fax: 855-350-9724

Toll Free Number: 888-308-2248 (Required per NAC 639.708)

E-mail: DWAYNE@MEDEXPRESS.CO.UK Website: N/A

Managing Pharmacist: TANYA RENAY FINLAY License Number: PS50240

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☑	Retail	☐ ☑	Off-site Cognitive Services
☐ ☑	Hospital (# beds ____)	☐ ☑	Parenteral **
☐ ☑	Internet	☐ ☑	Parenteral (outpatient)
☐ ☑	Nuclear	☐ ☑	Outpatient/Discharge
☐ ☑	Ambulatory Surgery Center	☑	Mail Service
☐ ☑	Community	☐ ☑	Long Term Care
☐ ☑	Other: _____	☐ ☑	Sterile Compounding **
		☑	Non Sterile Compounding
	All boxes must be checked	☐ ☑	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☑	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

CC

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5
☐ Partnership - Pages 1,2,3,6
☑ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Bluewater Healthcare PA LLC

Physical Address: 405 Stella St, Suite E West Monroe, LA 71291
(This must be a business address, we can not issue a license to a home address)

Mailing Address: Same as above

City: _____ State: _____ Zip Code: _____

Telephone: 800-715-1787 Fax: 800-715-1787

E-mail: bluewaterhealthcare@proton.com Website: NA

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 5 Tue: 9 to 5 Wed: 9 to 5 Thu: 9 to 5

Fri: to closed Sat: to closed Sun: to closed Holidays: to closed

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Michael Riggins

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: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

JXL

DD

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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☑ New MDEG ☐ Ownership Change

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation ☐ Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation ☐ Pages 1,2,3,5 ☐ Sole Owner ☐ Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: CAMPBELL MEDICAL SUPPLY INC

Physical Address: 11350 66TH ST SUITE 101 LARGO FLORIDA 33773

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

Mailing Address: 11350 66TH ST SUITE 101

City: Largo State: FLORIDA Zip Code: 33773

Telephone: (727) 914-3186 Fax: (727) 275-9607

E-mail: INFO@CAMPBELLMEDSUPPLY.COM Website: N/A

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 4 Tue: 9 to 4 Wed: 9 to 4 Thu: 9 to 4

Fri: 9 to 4 Sat: closed Sun: closed Holidays: closed.

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: MAURICE CAMPBELL

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: OFF THE SHELF ORTHOTICS

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: N/A Telephone: N/A

EE

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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☒ New MDEG ☐ Ownership Change

(Please provide current license number if making changes: MP or MW_____)

☒ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: FedEx Supply Chain, Inc.

Physical Address: 9570 Logistics Court, Columbus, OH 43217

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

Mailing Address: Attn: Licensing, 700 Cranberry Woods Drive

City: Cranberry Township State: PA Zip Code: 16066

Telephone: 614-530-8691 Fax: N/A

E-mail: FSC-pharmalicensing@fedex.com Website: supplychain.fedex.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 6AM to 11:30 Tue: 6AM to 11:30PM Wed: 6AM to 11:30PM Thu: 6AM to 11:30 PM

Fri: 6AM to 11:30 Sat: 6AM to 6PM Sun: 6AM to 6PM Holidays: ____ to ____

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Michael Hay - General Manager

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: Non-RX Medical Devices

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

FF

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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☒ New MDEG ☐ Ownership Change
(Please provide current license number if making changes: MP or MW_____)

☒ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5
☐ Partnership - Pages 1,2,3,6
☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: FedEx Supply Chain, Inc.

Physical Address: 25300 Globe Street, Moreno Valley, CA 92551
(This must be a business address, we can not issue a license to a home address)

Mailing Address: Attn: Licensing, Cranberry Woods Drive

City: Cranberry Township State: PA Zip Code: 16066

Telephone: 951-251-7101 Fax: N/A

E-mail: FSC-pharmalicensing@fedex.com Website: supplychain.fedex.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 6AM to 11:30 PM Tue: 6AM to 11:30PM Wed: 6AM to 11:30PM Thu: 6AM to 11:30 PM

Fri: 6AM to 11:30 PM Sat: ~~to~~ Sun: ~~to~~ Holidays: ~~to~~

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Antonio Zurria - Operations Manager

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: Non-Rx Medical Devices

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

3/21

GG

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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☑ New MDEG ☐ Ownership Change

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation ☐ Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation ☐ Pages 1,2,3,5 ☑ Sole Owner ☑ Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Frontier Medical LLC

Physical Address: 7295 S. ~~2050 E.~~ 2050 E. South Weber UT 84405

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

Mailing Address: 7295 S. 2050 E.

City: South Weber State: UT Zip Code: 84405

Telephone: 801-979-4638 Fax: 801-605-8549

E-mail: Kansas@ftmed.net Website: Cell: 801-503-8693

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 8 to 5 Sat: closed Sun: closed Holidays: closed

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Kansas Whitear

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

☐ Medical Gases**

☑ Respiratory Equipment** - Oxygen Concentrator

☐ Life-sustaining equipment**

☑ Diabetic Supplies

☑ Assistive Equipment

☐ Parenteral and Enteral Equipment**

☐ Orthotics and Prosethics

Other: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: Kody Whitear Telephone: 801-458-5639

3/29 HH

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4

☐ Non Publicly Traded Corporation – Pages 1,2,3,5

☐ Partnership - Pages 1,2,3,6

☒ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Full Range Rehab, LLC

Physical Address: 4722 Interstate Drive, Suite K Cincinnati, OH 45246

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

Mailing Address: 4722 Interstate Drive, Suite K

City: Cincinnati State: OH Zip Code: 45246

Telephone: 513-330-5995 Fax: 800-819-7985

E-mail: barbara@fullrangerehab.com Website: www.fullrangerehab.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 10:00am to 4:00pm Tue: 10:00am to 4:00pm Wed: 10:00am to 4:00pm Thu: 10:00am to 4:00pm

Fri: 10:00am to 4:00pm Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Jay Weiner

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: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

II

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Handi Medical Supply

Physical Address: 2505 University Ave W, St Paul, MN 55114

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

Mailing Address: 2505 University Ave W

City: St Paul State: MN Zip Code: 55114

Telephone: 651-644-9770 Fax: 651-644-0602

E-mail: _____ Website: www.handimedical.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: 9Am to 3Pm Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Cindy Tomlinson - ctomlinson@handimedical.com

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: Ostomy, urological & Wound Supplies

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: n/a Telephone: n/a

JJ

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation Pages 1,2,3,5 ☒ Sole Owner Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Healthcare DME LLC

Physical Address: 2911 Carpenter Rd, Ann Arbor, MI-48108-1163

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

Mailing Address: 2911 Carpenter Rd

City: Ann Arbor State: MI Zip Code: 48108-1163

Telephone: 734-975-6668 Fax: 734-975-6678

E-mail: Shaz@healthcaredme.com Website: www.healthcaredme.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9:00 to 5:00 Tue: 9:00 to 5:00 Wed: 9:00 to 5:00 Thu: 9:00 to 5:00

Fri: 9:00 to 5:00 Sat: ___ to ___ Sun: ___ to ___ Holidays: ___ to ___

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Ashfaq Kadwani

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: Custom Fabricated burn Garment

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: Ashfaq Kadwani Telephone: 877-240-7363

KK

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☒ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Performance Plus Medical Equipment, LLC

Physical Address: 2100 S. Brentwood Ste C

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

Mailing Address: _____

City: Springfield State: MO Zip Code: 65804

Telephone: 417-720-1662 Fax: 417-755-7209

E-mail: dora@specialtymgt.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 3pm Tue: 9am to 3pm Wed: 9am to 3pm Thu: 9am to 3pm

Fri: 9am to 3pm Sat: ___ to ___ Sun: ___ to ___ Holidays: ___ to ___

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Carrie Quesenberry

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: Urilogical supplies

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

3/27

LL

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Preferred Homecare

Physical Address: 4603 E Hammond Lane, Phoenix, Arizona 85034

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

Mailing Address: PO Box 9004, Attn: Licensing

City: Clearwater State: FL Zip Code: 33758

Telephone: 480-993-2097 Fax: 480-505-9091

E-mail: licensing@lincare.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 0800 to 1700 Tue: 0800 to 1700 Wed: 0800 to 1700 Thu: 0800 to 1700

Fri: 0800 to 1700 Sat: ____ to ____ Sun: ____ to ____ Holidays: ____ to ____

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Oscar De Los Monteros

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: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: Oscar De Los Monteros Telephone: 480-993-2097

MM

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5
☒ Partnership - Pages 1,2,3,6
☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Rapid Reboot Recovery Products LLC

Physical Address: 1396 W 200 S Ste 2A, Lindon UT 84042

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

Mailing Address: Same as above

City: Lindon State: UT Zip Code: 84042

Telephone: 801-899-7511 Fax: 833-787-4767

E-mail: info@rapidreboot.com Website: rapidreboot.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 5 Tue: 9 to 5 Wed: 9 to 5 Thu: 9 to 5

Fri: 9 to 5 Sat: ~~to~~ Sun: ~~to~~ Holidays: ~~to~~

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Bailey Jenkins

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: pneumatic compression devices

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

NN

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☑ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Graham-Sego Corporation dba Sego's Home Medical Equipment

Physical Address: 108 Sausalito Blvd, Casselberry, FL 32707

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

Mailing Address: Same as above

City: _____ State: _____ Zip Code: _____

Telephone: 407-260-6002 Fax: 407-260-0579

E-mail: sego@segoshme.com Website: www.Segoshme.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: — to — Sun: — to — Holidays: — to —

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Edwin Sego

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 Prosethics

☐ Diabetic Supplies Other: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

00

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation ☐Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☑ Non Publicly Traded Corporation ☐Pages 1,2,3,5 ☐ Sole Owner ☐Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Graham-Sego Corporation dba Sego's Home Medical Equipment

Physical Address: 1225 Garden St., Titusville, FL 32796

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

Mailing Address: Same as above

City: _____ State: _____ Zip Code: _____

Telephone: 321-268-0179 Fax: 321-264-2780

E-mail: Sego@segoshme.com Website: www.segoshme.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: — to — Sun: — to — Holidays: — to —

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Edwin Sego

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: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

3/12 PP

985 Damonte Ranch Parkway Suite 206 Reno, NV 89521

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation ☐ Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation ☒ Pages 1,2,3,5 ☐ Sole Owner ☐ Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: United Medical Providers, Inc.

Physical Address: 8010 Crowder Blvd, New Orleans, LA 70127

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

Mailing Address: 8010 Crowder Blvd

City: New Orleans State: LA Zip Code: 70127

Telephone: 504-520-8372 Fax: 504-520-8376

E-mail: mickey@umponline.com Website: www.umponline.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 4:30 Tue: 9 to 4:30 Wed: 9 to 4:30 Thu: 9 to 4:30 Central Time

Fri: 9 to 4:30 Sat: N to A Sun: N to A Holidays: N to A

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Mickey Whittle

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: Urologicals, Ostomy + Wound care supplies

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

2nd location in NV

QQ

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Pulmonary Solutions, LLC

Physical Address: 50 Freeport Blvd, Suite 24, Sparks, NV 89431

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

Mailing Address: 7660 W Sahara Ave

City: Las Vegas State: NV Zip Code: 89117

Telephone: 877-290-8636 Fax: 877-807-6561

E-mail: hr@pulmonarysolutions.net Website: pulmonarySolutions.net

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5pm Tue: 9am to 5pm Wed: 9am to 5pm Thu: 9am to 5pm

Fri: 9am to 5pm Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Matt Rotter

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: Sleep equipment CPAP, BIPAP

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Matt Rotter Telephone: 877-290-8636

RR

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☒ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Azura Surgery Center Las Vegas

Physical Address: 2450 Fire Mesa Street Suite 100

City: Las Vegas State: NV Zip Code: 89128

Telephone: 702-341-8031 Fax: 725-444-1331

Toll Free Number: _____ E-mail: Lynda.Teator@azuracare.com

Website: NKDHC.com

Managing Pharmacist: Danielle Plummer License Number: 19380

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☒ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☒	☐ Ambulatory Surgery Center	☐	☒ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☐	☒ Sterile Compounding
		☐	☒ Non Sterile Compounding
All boxes must be checked		☐	☒ Mail Service Sterile Compounding
For the application to be complete		☒	☐ Other Services: Incenter only

SS

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206– Reno, NV 89521 – (775) 850-1440

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH_____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b ☐ Partnership - Pages 1,2,6,10,11a&b

☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b ☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Comprehensive Digestive Surgery Center

Physical Address: 8440 W Warm Springs Road

City: Las Vegas State: Zip Code: NV 89113 Telephone: (702) 970-2383

Fax: (702) 970-2382 Toll Free Number: _____

E-mail: kbackun@nevadagastro.com

Website: pending

Managing Pharmacist: Mary Grear License Number: 10687

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds_____)	☒	☐ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☒	☐ Ambulatory Surgery Center	☐	☑ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding
		☐	☑ Non Sterile Compounding
All boxes must be checked		☐	☑ Mail Service Sterile Compounding
For the application to be complete		☐	☑ Other Services: _____

TT

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☒ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Aratana Therapeutics, Inc.

Physical Address: 11400 Tomahawk Creek Parkway, Suite 340

City: Leawood State: KS Zip Code: 66211

Telephone Number: (844) 744-7389 Fax Number: (913) 904-9641

Toll Free Number: (844) 744-7389

E-mail: ART@slsny.com Website: www.aratana.com

Facility Manager: Virginia Ann Kleekamp

Professional qualifications and experience of facility manager: Quality assusance professional. Has been quality assurance manager at Aratana since 2017.

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers
☒ Other: Distributors and veteranarians

Type of Products to be handled or wholesaled by firm:

☐ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other:
☐ Hypodermic Devices
☒ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____

Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4
☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Athenex Pharmaceutical Division, LLC

Physical Address: 10 N. Martingale Rd., Suite 230R

City: Schaumburg State: IL Zip Code: 60173

Telephone Number: (847) 886-9515 Fax Number: (847) 744-9545

Toll Free Number: N/A

E-mail: AXP@slsny.com Website: www.athenex.com

Facility Manager: Albert A. Patterson

Professional qualifications and experience of facility manager: VP National Accounts and Designated Representative at Athenex since July 2016.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers
☒ Other: Distributors and US Government

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☒ Controlled Substances (include copy of DEA)
☒ Other: Biologics
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)
Application must be printed legibly or typed

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☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7
☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Biocon Pharma, Inc.

Physical Address: 485 Highway 1S, Suite B-305

City: Iselin State: NJ Zip Code: 08830

Telephone Number: (732) 636-2950 Fax Number: (732) 636-2951

Toll Free Number: N/A

E-mail: BCO@slsny.com Website: www.biocon.com

Facility Manager: Marcus P. Merritt

Professional qualifications and experience of facility manager: National Accounts Director responsible for business development and strategy for all phases of U.S. wholesale and retail supply channel pharmaceutical generic product distribution.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☒ Other: Distributors, US Government

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other:
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable** money order or cashier's check only)
Application must be printed legibly or typed

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☑ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☑ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Blupax Pharmaceuticals, LLC

Physical Address: 160 Raritan Center Parkway Unit 1

City: Edison State: NJ Zip Code: 08837

Telephone Number: 732-902-6760 Fax Number: 732-902-6761

Toll Free Number: _____

E-mail: nacama@blupaxPharma.com Website: www.blupaxpharma.com

Facility Manager: Amit Rahman

Professional qualifications and experience of facility manager: Systems and Logistics Manager; several years as operational manager

Types of licensed outlets or authorized persons firm will serve:

☑ Pharmacies ☑ Practitioners ☑ Hospitals ☑ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☑ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____

Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7

☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Casper Pharma LLC

Physical Address: 2 Tower Center Boulevard, Suite 1101C

City: East Brunswick State: NJ Zip Code: 08816

Telephone Number: 732-447-9797 Fax Number: 732-246-2175

Toll Free Number: 844-522-7737

E-mail: CSP@slsny.com Website: www.casperpharma.com

Facility Manager: Vimal Kavuru

Professional qualifications and experience of facility manager: Pharmacisl-

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☒ Hospitals ☒ Wholesalers

☒ Other: Distributors

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices

☐ Poisons or Chemicals

☐ Controlled Substances (include copy of DEA)

☐ Other:

☐ Hypodermic Devices

☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)
Application must be printed legibly or typed

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☑ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____
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☑ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Gilead Sciences, Inc.

Physical Address: 1800 Wheeler Avenue

City: La Verne State: CA Zip Code: 91750

Telephone Number: 800-939-9009 Fax Number: 800-639-9009

Toll Free Number: 800-939-9009

E-mail: ccs@gilead.com Website: www.gilead.com

Facility Manager: Gerard Jensen

Professional qualifications and experience of facility manager: See attached resume.

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☑ Wholesalers
☑ Other: Specialty Pharmacies

Type of Products to be handled or wholesaled by firm:

☑ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other:
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____

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☒ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Ironwood Pharmaceuticals, Inc.

Physical Address: 301 Binney Street

City: Cambridge State: MA Zip Code: 02142

Telephone Number: 617-621-7722 Fax Number: 617-494-0480

Toll Free Number: N/A

E-mail: Cjackson@ironwoodpharma.com Website: www.ironwoodpharma.com

Facility Manager: Corwin F. Jackson

Professional qualifications and experience of facility manager: Corwin F. Jackson has over 20 years of experience leading logistics operations for global organizations. At the company, he is responsible for all aspects of commercial supply chain.

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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☑ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____

Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Partnership - Pages 1,2,3,7
☑ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: La Jolla Pharma, LLC

Physical Address: 4550 Towne Centre Court, Suite 100

City: San Diego State: CA Zip Code: 92121

Telephone Number: (858) 207-4264 Fax Number: N/A

Toll Free Number: N/A

E-mail: medicalinformation@ljpc.com Website: www.lajollapharmaceutical.com

Facility Manager: Dennis M. Mulroy

Professional qualifications and experience of facility manager: See attached resume

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers
☑ Other: Specialty Distributors

Type of Products to be handled or wholesaled by firm:

☑ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7
☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Laser Pharmaceuticals, LLC

Physical Address: 1015 Nine North Drive, Suite 400

City: Alpharetta State: GA Zip Code: 30004-5945

Telephone Number: (770) 754-9846 Fax Number: (770) 754-9850

Toll Free Number: N/A

E-mail: LSR@slsny.com Website: www.laserpharmaceuticals.com

Facility Manager: Brenda Rogers Settlemyer

Professional qualifications and experience of facility manager: Dedicated and skilled business professional with a versatile administrative support skill set developed as an office manager and business owner. Has been officer manager/qaulity control at Laser Pharmaceuticals, LLC since 2014.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers
☒ Other: US Government, Distribution sites

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☒ Other: Over the counter pharmaceuticals
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

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☒ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: MannKind Corporation

Physical Address: 1 Casper Street

City: Danbury State: CT Zip Code: 06810

Telephone Number: (203) 798-8000 Fax Number: (203) 796-3676

Toll Free Number: N/A

E-mail: MKD@slsny.com Website: www.mannkind.corp

Facility Manager: Bruce W. Lemieux

Professional qualifications and experience of facility manager:
Responsible for directing all warehousing and logistics functions for 350,000 sq. ft. Danbury facility

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers
☒ Other: Manufacturers

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☒ Other: Biologics
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

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☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Provell Pharmaceuticals, LLC

Physical Address: 101 Hudson Street, Suite 2100 RM 2146

City: Jersey City State: NJ Zip Code: 07302

Telephone Number: (610) 942-8970 Fax Number: (610) 942-8973

Toll Free Number: N/A

E-mail: PPL@SLSNY.com Website: www.provellpharma.com

Facility Manager: Kurt Paul Kalm

Professional qualifications and experience of facility manager: Please see attached resume.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☒ Other: Distributors

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other:
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)
Application must be printed legibly or typed

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☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4
☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Sagent Pharmaceuticals, Inc.

Physical Address: 1901 North Roselle Road, Suite 450 RM 4032

City: Schaumburg State: IL Zip Code: 60195

Telephone Number: 847-908-1600 Fax Number: 847-908-1601

Toll Free Number: N/A

E-mail: SAG@slsny.com Website: www.sagentpharma.com

Facility Manager: Jerry C. Webb

Professional qualifications and experience of facility manager: Over 30 years pharmaceutical manufacturing and distribution experience, plant manager for 4 different facilities (manufacturing). Executive for multiple plants and distribution centers.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☒ Hospitals ☒ Wholesalers
☒ Other: Distributors

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☒ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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Application must be printed legibly or typed

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☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7
☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Sentiss Pharmaceuticals, LLC

Physical Address: 107 Avenida de la Estrella

City: San Clemente State: CA Zip Code: 92672

Telephone Number: (949) 218-1768 Fax Number: (845) 544-2481

Toll Free Number: N/A

E-mail: STS@slsny.com Website: www.sentisspharma.com

Facility Manager: Jena D. Thompson

Professional qualifications and experience of facility manager: Sales, marketing, and business development manager with extensive experience in the generic pharmaceutical business.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)
Application must be printed legibly or typed

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 Wholesaler 3PL or ☐ Ownership Change (Provide current license number if making changes: WH____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4
☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: UPS Supply Chain Solutions, Inc

Physical Address: 775 East Drive

City: Carol Stream State: IL Zip Code: 60188

Telephone Number: 630-588-8168 Fax Number: 630-588-8313

Toll Free Number: _____

E-mail: falicensing@ups.com Website: www.ups.com

Facility Manager: Brandon Sorrels

Professional qualifications and experience of facility manager: See attached

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____

☒ Hypodermic Devices
☒ Veterinary Legend Drugs

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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

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Application must be printed legibly or typed

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☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH____

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☒ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Vertex Pharmaceuticals Incorporated

Physical Address: 50 Northern Avenue

City: Boston State: MA Zip Code: 02210

Telephone Number: 617-341-6100 Fax Number: 617-341-6803

Toll Free Number: N/A

E-mail: State_License@vrtx.com Website: www.vrtx.com

Facility Manager: Stuart Arbuckle

Professional qualifications and experience of facility manager: See Attachment C

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

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MATRIX GUIDELINE FOR DISCIPLINARY ACTIONS

	1st Action	2nd Action	3rd Action
Non ingested error	Letter	Letter	Hearing
No counseling	$750.00	Counseling CE + $1000.00	Hearing
Attorney Fees and Costs	Actual	Actual	Actual
Ingested no potential harm	$500.00	$1000.00	Hearing
Ingested with potential harm or adverse outcomes	$1000.00	Hearing	Hearing
Ingested with negative outcome or patient discomfort. No institution intervention	Hearing	Hearing	Hearing
Ingested with significant negative health circumstance. With institution admit	Hearing	Hearing	Hearing
Ingested with death related to inappropriate drug therapy	Hearing	Hearing	Hearing

The investigative committee will review each case individually and may recommend a board hearing, particularly with mitigating circumstances such as inappropriate technician involvement or pharmacist malfeasance.

In certain cases with ingested errors and significant negative health circumstances requiring institutional care, the investigative committee recommendation will be a board hearing.

In all death cases resulting from inappropriate drug therapy a board hearing will occur.

Attorney fees and costs may be added in contested disciplinary actions requiring extensive attorney preparation and presentation and are not described in the above matrix.

The board has directed that ownership may be charged in disciplinary cases. In non-ingested errors copies of admonition letters will be sent to management. Accumulative actions for ownership monitoring will be based upon a 3 year period. All actions including non-ingested errors will be given a case number and monitored.

The Board has the authority to fine from $0.00 to $10,000 for each Cause of Action.

Updated May 2019

FINDING	HARM	DISCIPLINE INDIVIDUAL	DISCIPLINE FACILITY
RPH DC and WB did not complete required CEs.	N/A	DC: $500 fine; $1,000 administrative fee; additional CEs; attend 3 of the next 4 Board meetings; complete and pass Nevada law. WB: $500 fine; $1,000 administrative fee; additional CEs; attend 3 of the next 4 Board meetings.	
RPH SB failed to speak to the prescriber before, at the time or after she declined to fill a patient's prescription for clopidogrel.	N/A	Fined $500; administrative fee of $1,000; 4 hours of CE related to cardiology or cardiac drugs.	Fined $1,000; an administrative fee of $2,000; establish Board-approved policies and procedures that are consistent with Nevada law and retrain its current and future pharmacists regarding the same.
RP allowed unlicensed staff to prescribe/order dangerous drugs and use his authority to obtain, administer, access and/or possess an inventory of dangerous drugs when he was not onsite and without his direct supervision. RP did not have a bona fide therapeutic relationship with the patients. RP purchased compounded dangerous drugs from a pharmacy not licensed with the Board.	N/A	RP shall receive a public letter of reprimand; his CS registration shall be placed on probation for a period of 12 months; fined $5,000; administrative fee of $2,500; establish policies and procedures. RP's offices/clinics are subject to quarterly inspections for one year.	N/A
RPH NR verified a prescription for 30 chlordiazepoxide 25 mg. capsules which was labeled and dispensed to the wrong patient. RPH JA failed to counsel the patient. PT LP deleted the prescription from the pharmacy system. ML was the managing pharmacist.	N/A	NR shall receive a letter of reprimand; fined $2,750; 2 additional hours of CE on error prevention. JA shall receive a letter of reprimand; fined $750; 2 additional hours of CE on patient counseling. LP fined $500; $1,000 administrative fee; attend three of the Board's next four	$1,000 fine; $1,500 administrative fee.

FINDING	HARM	DISCIPLINE INDIVIDUAL	DISCIPLINE FACILITY
		meetings on disciplinary day. ML shall complete 4 additional hours of CE on pharmacy management.	
PT MC diverted controlled substances from her employing pharmacy.	N/A	Revocation of pharmaceutical technician registration.	N/A
RPH SB did not renew his registration and worked 244 days unlicensed. He was also the PIC.	N/A	Fined $2,500 and $1,000 administrative fee.	Fined $5,000 fine and $2,683.99 administrative fee
RPH CD verified Risperidone 2 mg. tablets in the prescription bottle as the correct product for dispensing when the physician prescribed Ropinirole 2 mg. tablets. CD failed to adequately provide counseling.	N/A	Letter of reprimand; fined $1,000; $1,000 administrative fee; complete 2 CEs on error prevention.	WG-NV fined $1,000; $1,000 administrative fee. WG-FL fined $2,000; $1,000 administrative fee.
RPH JS dispensed medication labeled with incorrect instructions.	N/A	Letter of reprimand; $1,000.00 fine; $1,000.00 administrative fee; complete two additional CEs on error prevention.	Fined $1,000.00; $1,000.00 administrative fee.
RPH JCH filled and dispensed a Vancomycin prescription without the necessary knowledge and proper training, accepting verbal prescriptions from non-practitioners and failing to follow the prescription written by the prescriber.	N/A	Registration revoked; the revocation is stayed with conditions: take and pass the NAPLEX and MPJE; pay a $5,000.00 fine; pay a $1,250.00 administrative fee. Registration shall be placed on probation for four years during which time he cannot work as a managing pharmacist in any Nevada-licensed pharmacy; cannot engage in any form of compounding; and he must attend two Board meetings each year	$5,000.00 fine; $1,250.00 administrative fee; subject to quarterly inspections for one year at its own expense.

FINDING	HARM	DISCIPLINE INDIVIDUAL	DISCIPLINE FACILITY
		during the four year probationary periods.	
RPH WM was the managing pharmacist accountable for violations by personnel in his employ regarding the filling, compounding and record keeping of drug products	N/A	Letter of reprimand; $500.00 fine; $500.00 administrative fee.	$1,500.00 fine; $2,500.00 administrative fee; purchase software for tracking components used in its compounding services and the products it compounds; create new policies and procedures regarding medication management and compounding; subject to quarterly inspections at their own expense.
RPH KB verified data as correct when it was not and dispensed Prednisone 50 mg. tablets when 5 mg. tablets was prescribed.	The patient experienced a temporary negative outcome as a result of the error	$1,000.00 fine; an administrative fee of $500.00; complete two additional CEs related to prescription verification/error prevention and 2 CEs on to DUR warnings.	Pay an administrative fee of $1,000.00.

4A

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NOS. 17-008-RPH-A-N**
	)	**17-008-RPH-B-N**
Petitioner,	)	**17-008-PH-N**
v.	)	
	)	
STEVEN DOUGLAS DEVIN, R.PH.	)	**AMENDED**
Certificate of Registration No. 13260,	)	**NOTICE OF INTENDED ACTION**
	)	**AND ACCUSATION**
and	)	
	)	
MELANIE KELLY, R.PH.,	)	
Certificate of Registration No. 16028,	)	
	)	
and	)	
	)	
SAFEWAY PHARMACY #2656,	)	
Certificate of Registration No. PH01820,	)	
	)	
Respondents.	/	

J. David Wuest, in his official capacity as Executive Secretary of the Nevada State Board of Pharmacy, makes the following that will serve as both a notice of intended action under Nevada Revised Statutes (NRS) 233B.127(3), and as an accusation under NRS 622A.300(1) and NRS 639.241.

JURISDICTION

I.

The Nevada State Board of Pharmacy (Board) has jurisdiction over this matter because at the time of the events alleged herein, Respondents Steven Douglas Devin, R.Ph., Certificate of Registration No. 13260 (Devin), and Melanie Kelly, R.Ph., Certificate of Registration No. 16028 (Kelly), were pharmacists registered with the Board, and Respondent Safeway Pharmacy #2656 (Safeway Pharmacy) was a pharmacy licensed with the Board.

FACTUAL ALLEGATIONS

II.

In December 2016, a Safeway Pharmacy Professional Services Manager submitted a Report of Theft or Loss of Controlled Substances DEA 106 Form (DEA 106) to the Board Office.

III.

The DEA 106 documented a theft or loss of one thousand ninety-five (1,095) Tramadol 50 mg. tablets from Safeway Pharmacy. The report indicated that a "person of interest" was identified and "terminated for policy violations" related to the theft or loss.

IV.

Respondent Devin is the "person of interest" identified in the DEA 106.

V.

Safeway Pharmacy terminated Devin from his employment as a staff pharmacist for making numerous negative adjustments to the store's Tramadol inventory count in the store's computer system.

VI.

Devin admitted to recording negative adjustments to the tramadol inventory in Safeway Pharmacy's computer system. He claims he made those adjustments to match the actual number of tablets in the store's inventory.

VII.

Devin did not file a DEA 106 to correspond to each negative adjudgment he made to Safeway Pharmacy's computer system, nor did he report the tramadol shortages to Safeway Pharmacy management.

VIII.

Safeway Pharmacy's Tramadol Pinpoint Audit report, which details any adjustments made to its Tramadol inventory, shows each of the adjustments made by Devin. Those adjustments are summarized as follows:

Date	No. of Tablets
July 14, 2016	-50
July 30, 2016	-200
August 8, 2016	-115
September 1, 2016	-1,048
September 10, 2016	-49
September 15, 2016	-95
September 22, 2016	-230
October 14, 2016	-166
Total Negative Adjustments	-1,953

September 3, 2016	+771
October 16, 2016	+139
Total Positive Adjustments	+910

IX.

Devin could not explain the tramadol shortages. He denies diverting the tramadol for his own personal use.

X.

Devin stated that on several occasions he has removed prescription-strength ibuprofen from Safeway Pharmacy's pharmacy stock without a prescription and without paying for it. He later recanted those statements.

XI.

During the time period when Devin was making manual adjustments to the inventory counts in Safeway Pharmacy's computer system, Safeway Pharmacy's computer system generated weekly Manual On-Hand Changes Reports. Those reports show any manual

adjustments made to the inventory counts in Safeway Pharmacy's computer system during the prior week.

XII.

Each Manual On-Hand Changes Report has on it the following statement, which places on the Pharmacy Manager the responsibility to review and sign each report:

> Review this report for inventory on-hand adjustments from the prior week. You are responsible for validating an appropriate business reason for every on-hand adjustment before your acceptance by signing below. Retain in your inventory binder for a period of 6 months. Any discrepancies must be immediately reported to your PRM.

This directive is repeated at the end of every weekly report, directly above the signature line.

XIII.

Respondent Kelly, the Pharmacy Manager at Safeway Pharmacy at the time Devin made adjustments to the pharmacy's inventory, did not regularly review the weekly reports that were available to her.

XIV.

Kelly allowed Devin to review and sign the weekly adjustment reports on her behalf.

XV.

Kelly should have known that Devin was making frequent manual adjustments to Safeway Pharmacy's inventory.

XVI.

On November 17, 2016, Safeway Pharmacy suspended Devin from his position as a staff pharmacist at its store.

XVII.

As of November 23, 2016—the end of Safeway Pharmacy's internal investigation—Safeway Pharmacy reported that it had not seen any additional Tramadol shortages since Devin's suspension.

XVIII.

On May 31, 2018, Devin surrendered his pharmacist license, Certificate of Registration No. #13260, effective immediately at that time.

FIRST CAUSE OF ACTION
(Respondent Steven Devin)

XIX.

"Performing or in any way being a party to any fraudulent or deceitful practice or transaction" constitutes "unprofessional conduct and conduct contrary to the public interest." Nevada Administrative Code (NAC) 639.945(1)(g) and (h). Engaging in conduct that constitutes unprofessional conduct or that is contrary to the public interest is grounds for suspension or revocation of any license issued by the Board. Nevada Revised Statute (NRS) 639.210(4).

Devin engaged in unprofessional conduct in violation of NAC 639.945(1)(h) by intentionally and repeatedly making numerous adjustments to the Tramadol count of Safeway Pharmacy's inventory to conceal significant tramadol losses.

SECOND CAUSE OF ACTION
(Respondent Steven Devin)

XX.

Devin engaged in unprofessional conduct in violation of NAC 639.945(1)(h) by repeatedly failing to report significant losses of Tramadol from Safeway Pharmacy to pharmacy management or reporting the losses to the DEA and the Board Office by filing a Report of Theft or Loss of Controlled Substances DEA 106 Form.

THIRD CAUSE OF ACTION
(Respondent Steven Devin)

XXI.

Devin engaged in unprofessional conduct in violation of NAC 639.945(1)(g) and (h) by diverting a dangerous drug, namely ibuprofen, from Safeway Pharmacy. Devin did not have a valid prescription for ibuprofen.

FOURTH CAUSE OF ACTION
Managing Pharmacist Responsibilities
(Respondent Melanie Kelly)

XXII.

As the managing pharmacist/pharmacist in charge of Safeway Pharmacy at the time of each of the violations alleged herein, Respondent Melanie Kelly is responsible for those violations pursuant to NRS 639.0087, NRS 639.220(3)(c), NAC 639.510(2), and NAC 639.945(1)(i).

FIFTH CAUSE OF ACTION
Pharmacy/Pharmacy Owner Responsibility
(Respondent Safeway Pharmacy #2656)

XXIII.

NAC 639.945(2) states that "[t]he owner of any business or facility licensed, certified or registered by the Board is responsible for the acts of all personnel in his or her employ". At the time of the violations alleged herein, Respondents Devin and Kelly were each Safeway Pharmacy employees. As such, Safeway Pharmacy is responsible for each of the violations alleged herein.

XXIV.

For the errors, misconduct and violations alleged above in the First, Second, Third, Fourth, and Fifth Causes of Action, Respondents, and each of them, are subject to discipline pursuant NRS 639.210(1), (4), (11) and (12), as well as NRS 639.230(5) and/or NRS 639.255.

XXV.

WHEREFORE, it is requested that the Nevada State Board of Pharmacy take appropriate disciplinary action with respect to the certificate of registration of these Respondents.

Signed this 23rd day of April, 2019.

J. David Wuest, Executive Secretary
Nevada State Board of Pharmacy

NOTICE TO RESPONDENT

You have the right to show the Nevada State Board of Pharmacy that your conduct, as alleged above, complies with all lawful requirements. NRS 233B.127(3). You have the right to a hearing before the Board to answer the Notice of Intended Action and Accusation and present evidence and argument on all issues involved, either personally or through counsel. NRS 233B.121; NRS 233B.127(3); NRS 622A.300(1) and (3); NRS 639.241. To do so, you must complete and file two (2) copies of the Answer and Notice of Defense served herewith, to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within twenty (20) days of your receipt of this Notice of Intended Action and Accusation. NRS 639.320; NRS 639.243.

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 17-008-RPH-A-N**
	)	
Petitioner,	)	
v.	)	**STATEMENT TO THE RESPONDENT**
	)	**NOTICE OF INTENDED ACTION**
STEVEN DOUGLAS DEVIN, R.PH.,	)	**AND ACCUSATION**
Certificate of Registration No. 13260,	)	**RIGHT TO HEARING**
	)	
Respondent.	/	

TO THE RESPONDENT ABOVE-NAMED: PLEASE TAKE NOTICE THAT:

I.

Pursuant to the authority and jurisdiction conferred upon the Nevada State Board of Pharmacy (Board) by NRS 639.241 to NRS 639.2576, inclusive, and NRS chapter 233B and 622A, a Notice of Intended Action and Accusation has been filed with the Board by the Petitioner, J. David Wuest, Executive Secretary for the Board, alleging grounds for imposition of disciplinary action by the Board against you, as is more fully explained and set forth in the Notice of Intended Action and Accusation served herewith and hereby incorporated reference herein.

II.

You have the right to show the Nevada State Board of Pharmacy that your conduct, as alleged above, complies with all lawful requirements. NRS 233B.127(3). You have the right to a hearing before the Board to answer the Notice of Intended Action and Accusation and present evidence and argument on all issues involved, either personally or through counsel. NRS 233B.121; NRS 233B.127(3); NRS 622A.300(1) and (3); NRS 639.241. To do so, you must complete and file two (2) copies of the Answer and Notice of Defense served herewith, to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within twenty (20) days of your receipt of this Statement and Notice, and of the Notice of Intended Action and Accusation served within. NRS 639.320; NRS 639.243.

III.

The Board has reserved Wednesday, June 5, 2019, as the date for a hearing on this matter at the Hyatt Place, 1790 East Plumb Lane, Reno, Nevada. The hour of the hearing will be set by letter to follow.

IV.

Pursuant to NRS 241.033 and 241.034, please be advised that the hearing is a public meeting, and the Board may, without further notice, take administrative action against you if the Board determines that such administrative action is warranted after considering your character, alleged misconduct, professional competence, or physical or mental health. The Board at its discretion may go into closed session to consider your character, alleged misconduct, professional competence, or physical or mental health. You may attend any closed session, have an attorney or other representative of your choosing present during any closed session, and present written evidence, provide testimony, and present witnesses relating to your character, alleged misconduct, professional competence, or physical or mental health during any closed session.

V.

Your failure to timely file an Answer and Notice of Defense constitutes an admission of the charges and waiver of the right to a hearing. NRS 639.244. If you fail to appear at the hearing and the Board finds that you were given sufficient legal notice of the hearing, the Board may accept the allegations as true and may proceed to consider the case and render a decision. NRS 622A.350.

DATED this 23rd day of April, 2019.

J. David Wuest, R.Ph., Executive Secretary
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 17-008-RPH-A-N**
	)	
Petitioner,	)	
v.	)	**ANSWER AND**
	)	**NOTICE OF DEFENSE**
STEVEN DOUGLAS DEVIN, R.PH.,	)	
Certificate of Registration No. 13260,	)	
	)	
Respondent.	/	

Respondent above named, in answer to the Notice of Intended Action and Accusation filed in the above-entitled matter before the Nevada State Board of Pharmacy, declares:

1. That her objection to the Notice of Intended Action and Accusation as being incomplete or failing to state clearly the charges against her, is hereby interposed on the following grounds: (State specific objections or insert "none").

Please see attached letter.

2. That, in answer to the Notice of Intended Action and Accusation, she admits, denies and alleges as follows:

Please see attached letter.

I hereby declare, under penalty of perjury, that the foregoing Answer and Notice of Defense, and all facts therein stated, are true and correct to the best of my knowledge.

DATED this 15 day of ~~April~~ MAY, 2019.

SDD

Steven Douglas Devin, R.Ph.

Dear Board,

I wish to reply to your most recent accusation, which seems to be the same as your previous accusation of a year ago.

The accusation implies, but does not charge, that I was responsible for the loss of a large amount of tramadol. I addressed this in my initial interview with the Safeway investigator and in both my interviews with the board inspector, and I will leave that matter as it is.

I am being accused of two things- failing to submit reports to the DEA of missing controlled substances, and having said that at some time in my career I had taken a Motrin from a pharmacy.

I have admitted to failing to submit the required DEA 106 reports. I simply adjusted the computer totals in the pharmacy to match the on-hand physical totals for tramadol, and thought no more about it. I did not suspect diversion taking place- I assumed that since so many other totals were being constantly adjusted, that the computer was simply wrong. I can only think that since I had dispensed tramadol for at least 15 years as a non-controlled substance, I simply didn't think of it as a controlled substance at that point. When tramadol became a controlled drug in 2014, I was not working in retail pharmacy, and didn't see it as a controlled drug until I began working in Sparks at Safeway. This is not an excuse, it is simply my best guess as to why I failed to submit the reports. I knew about the necessity to file such reports for a C-II drug, but didn't think of it in regard to tramadol. At no time was I told that I was failing to submit such reports.

As to the Motrin accusation- this is crap. I was asked if I had EVER taken a drug from the pharmacy, and in the spirit of disclosure, I said that I was sure that at some point in my career I had taken a Motrin. I wasn't even thinking of this pharmacy- it could have been one of many, and not all were Nevada licensed. The Safeway investigator that asked that question immediately pounced and wanted to know when I took it, and I replied I couldn't even remember doing so, which meant it couldn't have been recently. He took it to mean that I was taking multiple doses of Motrin from this pharmacy, even though there is no significant missing Motrin, to my knowledge, from this pharmacy. When it was reported to the board, the board investigator took the same approach, and when I tried to correct his accusation, seemed to hear what I was saying, but the charge remained that I had taken multiple Motrin from this pharmacy on multiple occasions. I did not "recant" my statement- it was misrepresented from the start and never corrected.

Sincerely,

Steve Devin

SDV

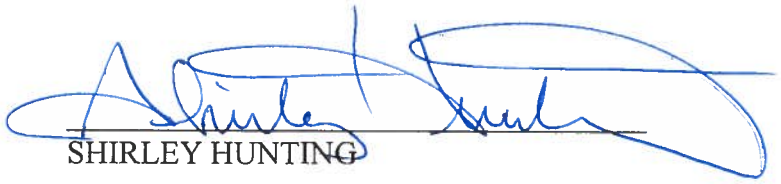
CERTIFICATE OF SERVICE

I certify that I am an employee of the Nevada State Board of Pharmacy, and that on this 23rd day of April 2019, I served a true and correct copy of the foregoing document by Certified U.S. Mail to the following:

Steven Devin, R.Ph.
9164 Kenton Trail
Reno, NV 89523

Melanie Kelly, R.Ph.
3737 Banfi Ct.
Sparks, NV 89436

Safeway Pharmacy #2656
2858 Vista Blvd.
Sparks, NV 89434



SHIRLEY HUNTING

4B

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 17-008-RPH-B-N**
	)	
Petitioner,	)	
v.	)	**STATEMENT TO THE RESPONDENT**
	)	**NOTICE OF INTENDED ACTION**
MELANIE KELLY, R.PH.,	)	**AND ACCUSATION**
Certificate of Registration No. 16028,	)	**RIGHT TO HEARING**
	)	
Respondent.	/	

TO THE RESPONDENT ABOVE-NAMED: PLEASE TAKE NOTICE THAT:

I.

Pursuant to the authority and jurisdiction conferred upon the Nevada State Board of Pharmacy (Board) by NRS 639.241 to NRS 639.2576, inclusive, and NRS chapter 233B and 622A, a Notice of Intended Action and Accusation has been filed with the Board by the Petitioner, J. David Wuest, Executive Secretary for the Board, alleging grounds for imposition of disciplinary action by the Board against you, as is more fully explained and set forth in the Notice of Intended Action and Accusation served herewith and hereby incorporated reference herein.

II.

You have the right to show the Nevada State Board of Pharmacy that your conduct, as alleged above, complies with all lawful requirements. NRS 233B.127(3). You have the right to a hearing before the Board to answer the Notice of Intended Action and Accusation and present evidence and argument on all issues involved, either personally or through counsel. NRS 233B.121; NRS 233B.127(3); NRS 622A.300(1) and (3); NRS 639.241. To do so, you must complete and file two (2) copies of the Answer and Notice of Defense served herewith, to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within twenty (20) days of your receipt of this Statement and Notice, and of the Notice of Intended Action and Accusation served within. NRS 639.320; NRS 639.243.

III.

The Board has reserved Wednesday, June 5, 2019, as the date for a hearing on this matter at the Hyatt Place, 1790 East Plumb Lane, Reno, Nevada. The hour of the hearing will be set by letter to follow.

IV.

Pursuant to NRS 241.033 and 241.034, please be advised that the hearing is a public meeting, and the Board may, without further notice, take administrative action against you if the Board determines that such administrative action is warranted after considering your character, alleged misconduct, professional competence, or physical or mental health. The Board at its discretion may go into closed session to consider your character, alleged misconduct, professional competence, or physical or mental health. You may attend any closed session, have an attorney or other representative of your choosing present during any closed session, and present written evidence, provide testimony, and present witnesses relating to your character, alleged misconduct, professional competence, or physical or mental health during any closed session.

V.

Your failure to timely file an Answer and Notice of Defense constitutes an admission of the charges and waiver of the right to a hearing. NRS 639.244. If you fail to appear at the hearing and the Board finds that you were given sufficient legal notice of the hearing, the Board may accept the allegations as true and may proceed to consider the case and render a decision. NRS 622A.350.

DATED this 23rd day of April, 2019.

J. David Wuest, R.Ph., Executive Secretary
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 17-008-RPH-B-N**
	)	
Petitioner,	)	
v.	)	**ANSWER AND**
	)	**NOTICE OF DEFENSE**
MELANIE KELLY, R.PH.,	)	
Certificate of Registration No. 16028,	)	
	)	
Respondent.	/	

Respondent above named, in answer to the Notice of Intended Action and Accusation filed in the above-entitled matter before the Nevada State Board of Pharmacy, declares:

1. That her objection to the Notice of Intended Action and Accusation as being incomplete or failing to state clearly the charges against her, is hereby interposed on the following grounds: (State specific objections or insert "none").

2. That, in answer to the Notice of Intended Action and Accusation, she admits, denies and alleges as follows:

I hereby declare, under penalty of perjury, that the foregoing Answer and Notice of Defense, and all facts therein stated, are true and correct to the best of my knowledge.

DATED this _____ day of April, 2019.

_____
Melanie Kelly, R.Ph.

Albertsons Companies

May 14, 2019

J. David Wuest, Executive Secretary
Nevada Board of Pharmacy
985 Damonte Ranch Parkway, Suite 206
Reno, NV 89521

Re: Case Nos. 17-008-RPH-B-N (Melanie Kelly, Registration No. 16028) and 17-008-PH-N (Safeway Pharmacy #2656, Registration No. PH01820)

Dear Mr. Wuest:

Provided herein is our written response on behalf of Safeway Pharmacy #2656 and its Pharmacist-in-Charge Melanie Kelly (hereinafter "Respondents") to the allegations presented in the Amended Notice of Intended Action and Accusation referenced above. The Respondents admit the Factual Allegations stated in paragraphs II through XII of the Accusation.

For paragraphs XIII through XV, Respondent Kelly admits that Mr. Devin was allowed to review the adjustment reports that were generated on Sunday by the pharmacy system being used during this timeframe (PDX Classic). Ms. Kelly explains that the reason for this was that Mr. Devin regularly worked on Sunday when this report printed, appeared to be responsible in his duties, and had otherwise given Ms. Kelly no reason to suspect him of diversion. Respondent Safeway #2656 admits paragraphs XVI and XVII. Respondents have no basis on which to admit or deny the facts stated in paragraph XVIII.

As to the stated Causes of Action against these Respondents, Respondent Kelly acknowledges the oversight responsibilities assigned to her as a pharmacist-in-charge under Nevada law. Once Ms. Kelly learned of the actions of Mr. Devin, she took immediate steps to require all staff members to back count controlled substance fills and keep a running total on the stock bottle of the amount contained therein. Additionally, for 12 months following the resolution of this matter, Ms. Kelly has agreed to print the inventory adjustment report weekly (which no longer automatically prints due to a pharmacy system upgrade), review all inventory adjustments by staff members, and resolve any unexplained adjustments. Upon completion, Ms. Kelly will sign and date the report and retain it on file for inspection upon request.

As to the Fifth Cause of Action, Safeway acknowledges that Nevada's Board Rules also assigns responsibility to a business registrant for the acts of its employees, including any violations of the law. In this case, an internal investigation was initiated based on reported losses. This investigation quickly identified Mr. Devin as the primary suspect and prompt action was taken to remove Mr. Devin from the pharmacy.

In addition to the steps taken at this specific location, Albertsons Companies (parent company of Safeway Inc.) has taken a number of steps to detect and prevent diversion in its pharmacies, including:

- Enhanced training on controlled substance recordkeeping requirements with a focus on the prevention of theft and diversion;
- Updated policies and procedures requiring double verification or checking in under camera coverage of all controlled substance product orders;
- Increased central monitoring of purchasing patterns and inventory adjustments;
- Procurement of highly diverted products in smaller count bottles;
- Random targeted counts of controlled substance products by company field evaluators;

- Revised the cycle count processes to ensure more frequent counting of targeted controlled substances;
- Increased camera coverage in pharmacies; and
- Implemented diversion deterrent strategies such as notifying employees of ongoing CCTV monitoring.

We assure you that we take seriously our combined obligation to detect and, whenever possible, prevent diversion in our pharmacies. We are interested in resolving this matter expediently and on an informal basis if possible. We hope you and the Board will consider the steps taken toward this outcome. We would appreciate the opportunity to discuss with you the potential to resolve this matter as soon as possible. Also, feel free contact me at any time in this process at Anthony.Provenzano@Albertsons.com or by phone at (208) 395-3354.

Sincerely,

ALBERTSONS COMPANIES, INC.

Anthony Provenzano, PharmD
Vice President, Pharmacy Compliance

SAFEWAY PHARMACY #2656

Melanie Kelly, PIC

Cc: Dan Day, VP, Chief Compliance Officer

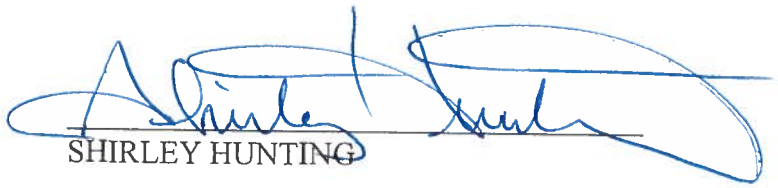
CERTIFICATE OF SERVICE

I certify that I am an employee of the Nevada State Board of Pharmacy, and that on this 23rd day of April 2019, I served a true and correct copy of the foregoing document by Certified U.S. Mail to the following:

Steven Devin, R.Ph.
9164 Kenton Trail
Reno, NV 89523

Melanie Kelly, R.Ph.
3737 Banfi Ct.
Sparks, NV 89436

Safeway Pharmacy #2656
2858 Vista Blvd.
Sparks, NV 89434



SHIRLEY HUNTING

4C

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 17-008-PH-N**
	)	
Petitioner,	)	
v.	)	**STATEMENT TO THE RESPONDENT**
	)	**NOTICE OF INTENDED ACTION**
SAFEWAY PHARMACY #2656,	)	**AND ACCUSATION**
Certificate of Registration No. PH01820,	)	**RIGHT TO HEARING**
	)	
Respondent.	/	

TO THE RESPONDENT ABOVE-NAMED: PLEASE TAKE NOTICE THAT:

I.

Pursuant to the authority and jurisdiction conferred upon the Nevada State Board of Pharmacy (Board) by NRS 639.241 to NRS 639.2576, inclusive, and NRS chapter 233B and 622A, a Notice of Intended Action and Accusation has been filed with the Board by the Petitioner, J. David Wuest, Executive Secretary for the Board, alleging grounds for imposition of disciplinary action by the Board against you, as is more fully explained and set forth in the Notice of Intended Action and Accusation served herewith and hereby incorporated reference herein.

II.

You have the right to show the Nevada State Board of Pharmacy that your conduct, as alleged above, complies with all lawful requirements. NRS 233B.127(3). You have the right to a hearing before the Board to answer the Notice of Intended Action and Accusation and present evidence and argument on all issues involved, either personally or through counsel. NRS 233B.121; NRS 233B.127(3); NRS 622A.300(1) and (3); NRS 639.241. To do so, you must complete and file two (2) copies of the Answer and Notice of Defense served herewith, to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within twenty (20) days of your receipt of this Statement and Notice, and of the Notice of Intended Action and Accusation served within. NRS 639.320; NRS 639.243.

III.

The Board has reserved Wednesday, June 5, 2019, as the date for a hearing on this matter at the Hyatt Place, 1790 East Plumb Lane, Reno, Nevada. The hour of the hearing will be set by letter to follow.

IV.

Pursuant to NRS 241.033 and 241.034, please be advised that the hearing is a public meeting, and the Board may, without further notice, take administrative action against you if the Board determines that such administrative action is warranted after considering your character, alleged misconduct, professional competence, or physical or mental health. The Board at its discretion may go into closed session to consider your character, alleged misconduct, professional competence, or physical or mental health. You may attend any closed session, have an attorney or other representative of your choosing present during any closed session, and present written evidence, provide testimony, and present witnesses relating to your character, alleged misconduct, professional competence, or physical or mental health during any closed session.

V.

Your failure to timely file an Answer and Notice of Defense constitutes an admission of the charges and waiver of the right to a hearing. NRS 639.244. If you fail to appear at the hearing and the Board finds that you were given sufficient legal notice of the hearing, the Board may accept the allegations as true and may proceed to consider the case and render a decision. NRS 622A.350.

DATED this 23rd day of April, 2019.

J. David Wuest, R.Ph., Executive Secretary
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 17-008-PH-N**
	)	
Petitioner,	)	
v.	)	**ANSWER AND**
	)	**NOTICE OF DEFENSE**
SAFEWAY PHARMACY #2656,	)	
Certificate of Registration No. PH01820,	)	
	)	
Respondent.	/	

Respondent above named, in answer to the Notice of Intended Action and Accusation filed in the above-entitled matter before the Nevada State Board of Pharmacy, declares:

1. That his objection to the Notice of Intended Action and Accusation as being incomplete or failing to state clearly the charges against him, is hereby interposed on the following grounds: (State specific objections or insert "none")

2. That, in answer to the Notice of Intended Action and Accusation, he admits, denies and alleges as follows:

I hereby declare, under penalty of perjury, that the foregoing Answer and Notice of Defense, and all facts therein stated, are true and correct to the best of my knowledge.

DATED this _____ day of April, 2019.

_____
Type or print name

_____
Authorized Representative For
Safeway Pharmacy #2656

Albertsons Companies

May 14, 2019

J. David Wuest, Executive Secretary
Nevada Board of Pharmacy
985 Damonte Ranch Parkway, Suite 206
Reno, NV 89521

Re: *Case Nos. 17-008-RPH-B-N (Melanie Kelly, Registration No. 16028) and 17-008-PH-N (Safeway Pharmacy #2656, Registration No. PH01820)*

Dear Mr. Wuest:

Provided herein is our written response on behalf of Safeway Pharmacy #2656 and its Pharmacist-in-Charge Melanie Kelly (hereinafter "Respondents") to the allegations presented in the Amended Notice of Intended Action and Accusation referenced above. The Respondents admit the Factual Allegations stated in paragraphs II through XII of the Accusation.

For paragraphs XIII through XV, Respondent Kelly admits that Mr. Devin was allowed to review the adjustment reports that were generated on Sunday by the pharmacy system being used during this timeframe (PDX Classic). Ms. Kelly explains that the reason for this was that Mr. Devin regularly worked on Sunday when this report printed, appeared to be responsible in his duties, and had otherwise given Ms. Kelly no reason to suspect him of diversion. Respondent Safeway #2656 admits paragraphs XVI and XVII. Respondents have no basis on which to admit or deny the facts stated in paragraph XVIII.

As to the stated Causes of Action against these Respondents, Respondent Kelly acknowledges the oversight responsibilities assigned to her as a pharmacist-in-charge under Nevada law. Once Ms. Kelly learned of the actions of Mr. Devin, she took immediate steps to require all staff members to back count controlled substance fills and keep a running total on the stock bottle of the amount contained therein. Additionally, for 12 months following the resolution of this matter, Ms. Kelly has agreed to print the inventory adjustment report weekly (which no longer automatically prints due to a pharmacy system upgrade), review all inventory adjustments by staff members, and resolve any unexplained adjustments. Upon completion, Ms. Kelly will sign and date the report and retain it on file for inspection upon request.

As to the Fifth Cause of Action, Safeway acknowledges that Nevada's Board Rules also assigns responsibility to a business registrant for the acts of its employees, including any violations of the law. In this case, an internal investigation was initiated based on reported losses. This investigation quickly identified Mr. Devin as the primary suspect and prompt action was taken to remove Mr. Devin from the pharmacy.

In addition to the steps taken at this specific location, Albertsons Companies (parent company of Safeway Inc.) has taken a number of steps to detect and prevent diversion in its pharmacies, including:

- Enhanced training on controlled substance recordkeeping requirements with a focus on the prevention of theft and diversion;
- Updated policies and procedures requiring double verification or checking in under camera coverage of all controlled substance product orders;
- Increased central monitoring of purchasing patterns and inventory adjustments;
- Procurement of highly diverted products in smaller count bottles;
- Random targeted counts of controlled substance products by company field evaluators;

- Revised the cycle count processes to ensure more frequent counting of targeted controlled substances;
- Increased camera coverage in pharmacies; and
- Implemented diversion deterrent strategies such as notifying employees of ongoing CCTV monitoring.

We assure you that we take seriously our combined obligation to detect and, whenever possible, prevent diversion in our pharmacies. We are interested in resolving this matter expediently and on an informal basis if possible. We hope you and the Board will consider the steps taken toward this outcome. We would appreciate the opportunity to discuss with you the potential to resolve this matter as soon as possible. Also, feel free contact me at any time in this process at Anthony.Provenzano@Albertsons.com or by phone at (208) 395-3354.

Sincerely,

ALBERTSONS COMPANIES, INC.

Anthony Provenzano, PharmD
Vice President, Pharmacy Compliance

SAFEWAY PHARMACY #2656

Melanie Kelly, PIC

Cc: Dan Day, VP, Chief Compliance Officer

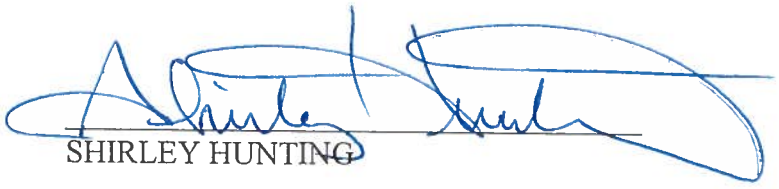
CERTIFICATE OF SERVICE

I certify that I am an employee of the Nevada State Board of Pharmacy, and that on this 23rd day of April 2019, I served a true and correct copy of the foregoing document by Certified U.S. Mail to the following:

Steven Devin, R.Ph.
9164 Kenton Trail
Reno, NV 89523

Melanie Kelly, R.Ph.
3737 Banfi Ct.
Sparks, NV 89436

Safeway Pharmacy #2656
2858 Vista Blvd.
Sparks, NV 89434



SHIRLEY HUNTING

4D

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 18-086-PH-N**
Petitioner,	)	
v.	)	
	)	**NOTICE OF INTENDED ACTION**
CVS PHARMACY #4691,	)	**AND ACCUSATION**
Certificate of Registration No. PH02471,	)	
Respondent.	)	

J. David Wuest, in his official capacity as Executive Secretary of the Nevada State Board of Pharmacy, makes the following that will serve as both a notice of intended action under Nevada Revised Statutes (NRS) 233B.127(3) and as an accusation under NRS 622A.300(1) and NRS 639.241.

JURISDICTION

I.

The Nevada State Board of Pharmacy (Board) has jurisdiction over this matter because at the time of the events alleged herein, Respondent CVS Pharmacy #4691, Certificate of Registration No. PH02471 (CVS), was a pharmacy licensed by the Board.

DISCIPLINARY HISTORY

II.

In March 2019, the Board entered a Stipulation and Order (Order) in the case of *Board of Pharmacy v. CVS Pharmacy #4691*, Case No. 17-089-PH-N. The Board found CVS Pharmacy #4691 responsible for the actions of its employees for violations resulting in a dispensing error. The error began with pharmaceutical technician Gisela Ochoa, who mistakenly entered a new prescription under the wrong patient name and patient profile. That error combined, with other

errors within the pharmacy, caused CVS to dispense a prescription for a schedule IV-controlled substance to a patient who did not have a prescription for that medication.

The Board ordered CVS to pay a fine of $1,000.00 and an administrative fee of $1,000.00 as part of that action.

FACTUAL ALLEGATIONS

III.

In October 2018, patient Laura S.[1] (Laura) provided three prescriptions from her practitioner to CVS, including prescriptions for Pantoprazole 40 mg. tablets (Rx No. 0778327), Sumatriptan (Rx No. 0783827) and Ondansetron (Rx No. 0791540).

IV.

On October 10, 2018, Laura's husband went to CVS to picked up Laura's medications.

V.

At the point of sale, pharmaceutical technician Gisela Ochoa (Ochoa) pulled Laura's Sumatriptan and Ondansetron prescriptions from the will-call bin and she inadvertently retrieved an unrelated prescription for Pantoprazole 40 mg. tablets (Rx No. 0746143) from the bin that was written for another patient, Linda S. (Linda).

VI.

At the cash register, Ochoa compounded the error when she scanned only the Sumatriptan and Ondansetron prescriptions, which correctly identified Laura as the patient. Ochoa did not scan the label on the Pantoprazole (Rx No. 0746143), which contained Linda's patient identifiers.

VII.

Ochoa placed all three medications, including Linda's Pantoprazole, in a bag and sold them to Laura's husband.

---

[1] CVS patients Laura S. and Linda S. have similar but distinguishable first and last names.

VIII.

Laura's husband detected the error after he left CVS.

IX.

Although Ochoa completed the sales transaction for all three prescriptions, CVS's cash register receipt and records incorrectly show that a different pharmaceutical technician, "Jenifer"[2], completed the transaction.

X.

Ochoa admits that she completed the point of sale scan of the subject prescriptions and completed the sales transaction using a computer where technician "Jenifer" was logged in. Ochoa claims that she did not log off and log in under her own credentials because the pharmacy was busy and she did not have "Jenifer's" passcode to sign off "Jenifer's" personal credentials.

XI.

Counseling was not required for these prescriptions.

FIRST CAUSE OF ACTION

XII.

Unprofessional conduct includes the failure by a licensee to follow strictly the instructions of a practitioner when labeling and dispensing a prescription. *See* NAC 639.945(1)(d). It also includes a licensee performing his duties in an "incompetent, unskillful or negligent manner". *See* NAC 639.945(1)(i). The owner of any business or facility licensed, certified or registered by the Board is responsible for the acts of all personnel in his or her employ. NAC 639.945(2).

Respondent Ochoa performed her duties in an incompetent, unskillful or negligent manger when she failed to strictly follow the instructions of a practitioner by dispensing a prescription to the wrong patient. As the pharmacy/pharmacy owner at which Ochoa violated the law as alleged herein, CVS #4691 is responsible for those violations pursuant to NRS

[2] Jenifer Grove was a pharmaceutical technician registered with the Board and employed by CVS at the time of the events alleged herein.

639.230(5) and NAC 639.945(2). CVS #4691 is therefore subject to discipline pursuant to NRS 639.210(4) and (12) and NRS 639.255.

SECOND CAUSE OF ACTION

XIII.

NAC 639.751 requires that a pharmacy's computer system "accurately depict the identity of the person entering [a] signature or initials" or other required information into the computer system.

Further, the owner of any business or facility licensed, certified or registered by the Board is responsible for the acts of all personnel in his or her employ. NAC 639.945(2).

Respondent Ochoa performed the point of sale prescription scans and sales transaction under another employee, Jenifer Grove's, computer initials. Jenifer Grove failed to maintain the security of her password. The actions of Ochoa and Grove violate of NAC 639.751 and NAC 639.930.

As the pharmacy/pharmacy owner at which the violations of law alleged herein occurred, CVS #4691 is responsible for those violations, including those of Ochoa and Grove pursuant to NRS 639.230(5) and NAC 639.945(2). CVS #4691 is therefore subject to discipline pursuant to NRS 639.210(4) and (12) and NRS 639.255, NAC 639.751 and NAC 639.930.

WHEREFORE, it is requested that the Nevada State Board of Pharmacy take appropriate disciplinary action with respect to the certificate of registration of this respondent.

Signed this 2ND day of May, 2019.

J. David Wuest, R.Ph., Executive Secretary,
Nevada State Board of Pharmacy

NOTICE TO RESPONDENT

You have the right to show the Nevada State Board of Pharmacy that your conduct, as alleged above, complies with all lawful requirements. NRS 233B.127(3). You have the right to a hearing before the Board to answer the Notice of Intended Action and Accusation and present evidence and argument on all issues involved, either personally or through counsel. NRS 233B.121; NRS 233B.127(3); NRS 622A.300(1) and (3); NRS 639.241. To do so, you must complete and file two (2) copies of the Answer and Notice of Defense served herewith, to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within twenty (20) days of your receipt of this Notice of Intended Action and Accusation. NRS 639.320; NRS 639.243.

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 18-086-PH-N**
	)	
Petitioner,	)	
v.	)	
	)	**STATEMENT TO THE**
CVS PHARMACY #4691	)	**RESPONDENT AND**
Certificate of Registration No. PH02471,	)	**NOTICE OF HEARING**
	)	
Respondent.	)	
	/	

TO THE RESPONDENT ABOVE-NAMED: PLEASE TAKE NOTICE THAT:

I.

Pursuant to the authority and jurisdiction conferred upon the Nevada State Board of Pharmacy (Board) by NRS 639.241 to NRS 639.2576, inclusive, and NRS chapter 233B and 622A, a Notice of Intended Action and Accusation has been filed with the Board by the Petitioner, J. David Wuest, Executive Secretary for the Board, alleging grounds for imposition of disciplinary action by the Board against you, as is more fully explained and set forth in the Notice of Intended Action and Accusation served herewith and hereby incorporated reference herein.

II.

You have the right to show the Nevada State Board of Pharmacy that your conduct, as alleged above, complies with all lawful requirements. NRS 233B.127(3). You have the right to a hearing before the Board to answer the Notice of Intended Action and Accusation and present evidence and argument on all issues involved, either personally or through counsel. NRS 233B.121; NRS 233B.127(3); NRS 622A.300(1) and (3); NRS 639.241. To do so, you must complete and file two (2) copies of the Answer and Notice of Defense served herewith, to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within twenty (20) days of your receipt of this Statement and Notice, and of the Notice of Intended Action and Accusation served within. NRS 639.320; NRS 639.243.

III.

The Board has scheduled your hearing on this matter for Wednesday, June 5, 2019, at 9:00 a.m. or soon thereafter. The hearing will occur at the Hyatt Place, 1790 East Plumb Lane, Reno, Nevada.

IV.

Pursuant to NRS 241.033 and 241.034, please be advised that the hearing is a public meeting, and the Board may, without further notice, take administrative action against you if the Board determines that such administrative action is warranted after considering your character, alleged misconduct, professional competence, or physical or mental health. The Board at its discretion may go into closed session to consider your character, alleged misconduct, professional competence, or physical or mental health. You may attend any closed session, have an attorney or other representative of your choosing present during any closed session, and present written evidence, provide testimony, and present witnesses relating to your character, alleged misconduct, professional competence, or physical or mental health during any closed session.

V.

Your failure to timely file an Answer and Notice of Defense constitutes an admission of the charges and waiver of the right to a hearing. NRS 639.244. If you fail to appear at the hearing and the Board finds that you were given sufficient legal notice of the hearing, the Board may accept the allegations as true and may proceed to consider the case and render a decision. NRS 622A.350.

DATED this 2nd day of May 2019.

J. David Wuest, R.Ph., Executive Secretary
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY, Petitioner, v. CVS PHARMACY #4691 Certificate of Registration No. PH02471, Respondent.	)	CASE NO. 18-086-PH-N ANSWER AND NOTICE OF DEFENSE

COMES NOW Respondent CVS Pharmacy #4691 ("CVS") and responds to the Notice of Intended Action and Accusation which was filed on May 2, 2019 by the Petitioner, The Nevada State Board of Pharmacy ("Board"). This Response shall also serve as Respondent CVS's Answer and Notice of Defense pursuant to NRS 639.244.

Respondent hereby declares:

1. That a hearing on the Accusation is requested.

2. That, in answer to the Accusation, Respondent CVS admits, denies, and/or alleges as follows:

I.

Respondent CVS admits that CVS #4691 is a pharmacy licensed by the Board, and as such, the Board has jurisdiction over this matter.

II.

Respondent admits the allegations of Paragraph II of the Accusation.

FACTUAL ALLEGATIONS

III.

Respondent admits the allegations of Paragraph III of the Accusation.

IV.

Respondent admits the allegations of Paragraph IV of the Accusation.

V.

Respondent admits the allegations of Paragraph V of the Accusation.

VI.

Respondent admits the allegations of Paragraph VI of the Accusation.

VII.

Respondent admits the allegations of Paragraph VII of the Accusation.

VIII.

Respondent can neither admit nor deny the allegations of Paragraph VIII of the Accusation.

IX.

Respondent admits the allegations of Paragraph IX of the Accusation.

X.

Respondent can neither admit nor deny the allegations of Paragraph X, as it does possess sufficient knowledge or information as to what technician Ochoa may have admitted directly to the Board. Respondent does not possess any information upon which it could refute the allegations in Paragraph X of the Accusation.

XI.

Respondent admits the allegations of Paragraph XI of the Accusation.

FIRST CAUSE OF ACTION

XII.

Respondent admits the first paragraph of Paragraph XII of the Accusation, wherein various sections of the NAC are cited. Respondent denies the remainder of Paragraph XII of the Accusation and holds the Petitioner to proof of same.

SECOND CAUSE OF ACTION

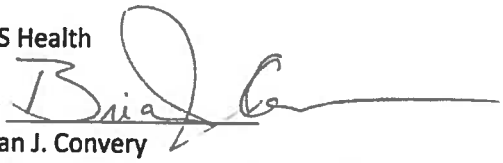
XIII.

Respondent admits the various sections of the NAC which are cited. Respondent denies the legal allegations in Paragraph XIII of the Accusation and holds the Petitioner to proof of same.

I hereby declare, under penalty of perjury, that the foregoing Answer and Notice of Defense, and all facts therein stated, are true and correct to the best of my knowledge.

Submitted by CVS #4691 on the 20th day of May, 2019.

CVS Health

By: 

Brian J. Convery
Senior Legal Counsel for CVS Health
Authorized Representative for CVS Pharmacy #4691

CERTIFICATE OF SERVICE

I certify that I am an employee of the Nevada State Board of Pharmacy, and that on this 2nd day of May, 2019, I served a true and correct copy of the foregoing document by Certified U.S. Mail to the following:

CVS Pharmacy #4691
5151 Sparks Blvd.
Sparks, NV 89436

SHIRLEY HUNTING

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NO. 18-086-PH-N**
	)	
Petitioner,	)	
v.	)	
	)	**STIPULATION AND ORDER**
CVS PHARMACY #4691,	)	
Certificate of Registration No. PH02471,	)	
	)	
Respondent.	/	

Brett Kandt, General Counsel for Petitioner the Nevada State Board of Pharmacy (Board), and Respondent CVS PHARMACY #4691 ("CVS"), Certificate of Registration No. PH02471, by and through counsel, Brian J. Convery, Esq., **HEREBY STIPULATE AND AGREE THAT**:

1. The Board has jurisdiction over Respondent CVS and this matter.

2. On or about May 2, 2019, Board Staff properly served the Notice of Intended Action and Accusation (Accusation) on file in this matter on Respondent CVS.

3. Respondent CVS filed an Answer to the Accusation on or about May 21, 2019.

4. Respondent CVS is fully aware of its right to seek the advice of counsel in this matter and obtained the advice of counsel prior to entering into this Stipulation.

5. Respondent CVS is aware of its right to a hearing on the matters alleged in the Accusation, its right to reconsideration, its right to appeal and any and all other rights which may be accorded to it pursuant to NRS Chapter 233B (Nevada Administrative Procedure Act), NRS Chapter 622A (Administrative Procedure Before Certain Regulatory Bodies), and NRS Chapter 639 (Nevada Pharmacy Act).

6. Conditioned on the acceptance of this Stipulation by the Board, and with the exception of the right to challenge any determination that Respondent CVS has failed to comply with the provisions of Paragraphs 9, 14 and/or 15 below, Respondent CVS hereby freely and

voluntarily waive its rights to a hearing, reconsideration, appeal and any and all other rights related to this action that may be accorded to it by NRS Chapter 233B (Nevada Administrative Procedure Act), NRS Chapter 622A (Administrative Procedure Before Certain Regulatory Bodies), and NRS Chapter 639 (Nevada Pharmacy Act).

7. Respondent CVS admits that evidence exists, and that Board staff prosecuting this case could present such evidence at an administrative hearing, which may be sufficient to establish a factual basis for the violations alleged in the Accusation, *to wit,* that:

A. At the time of the events alleged in the Accusation, Gisela Ochoa (Ochoa), Certificate of Registration No. PT18361, and Jenifer Grove (Grove), Certificate of Registration No. PT11159, were both pharmaceutical technicians registered by the Board and employed by Respondent CVS #4691.

B. Ochoa violated NAC 639.482, NAC 639.485 and NAC 639.910(1) and engaged in unprofessional conduct and conduct contrary to the public interest under NAC 639.945(1)(d) and (i) by dispensing a prescription drug to the wrong patient and performing the point of sale prescription scans and sales transaction under Grove's computer initials.

C. Grove violated NAC 639.482, NAC 639.485 and NAC 639.910(1) and engaged in unprofessional conduct and conduct contrary to the public interest under NAC 639.945(1)(d) and (i) by failing to maintain the security of her password.

D. As the pharmacy/pharmacy owner at which the violations of law alleged herein occurred, CVS #4691 is responsible for the violations committed by Ochoa and Grove pursuant to NRS 639.230(5) and NAC 639.945(2). CVS #4691 is therefore subject to discipline pursuant to NRS 639.210(4) and (12) and NRS 639.255, NAC 639.751 and NAC 639.930.

8. Those violations are plead with particularity in the Accusation, and are grounds for action pursuant to NRS 639.210 and NRS 639.255.

9. Based upon the Accusation and the foregoing admissions, the Board and Respondent CVS stipulate to the following penalties. Respondent CVS Pharmacy #4691, Certificate of Registration No. PH02471, shall:

A. Pay a fine of Five-Hundred Dollars ($500.00) associated with the violations indicated above; and

B. Pay Seven-Hundred Fifty Dollars ($750.00) to partially reimburse the Board for reasonable attorney's fees and costs incurred in investigating and prosecuting this matter.

10. Any failure by Respondent CVS to comply with the terms of this Order may result in issuance by the Executive Secretary of an order to show cause directing Respondent CVS to appear before the Board at the next regularly-scheduled meeting for a show cause hearing. If such a hearing results in a finding of a violation of this Order by Respondent CVS, the Board may impose additional discipline upon Respondent CVS not inconsistent with the provisions of NRS Chapter 639.

11. General Counsel will present this Stipulation to the Board for approval pursuant to NRS 622.330 at the Board's regularly scheduled public meeting on March 6, 2019, in Reno, Nevada. Respondent CVS's authorized representative(s) will appear at the meeting to answer questions from the Board Members and/or Board Staff. The Board Members and Staff may discuss and deliberate regarding this Stipulation, even if Respondent CVS or its counsel are not present at the meeting.

12. The Board has discretion to accept this Stipulation, but it is not obligated to do so. If this Stipulation is approved by the Board it shall be a public record pursuant to NRS 622.330.

13. If the Board rejects any part or all of this Stipulation, and unless they reach an alternative agreement on the record during the hearing, the parties agree that a full hearing on the merits of this matter may be heard by the Board. The terms and admissions herein may not be used or referred to in a full hearing on the merits of this matter.

14. Upon approval of this Stipulation by the Board, Respondent CVS shall pay the fine agreed to herein by *cashier's check* or *certified check* or *money order* made payable to "State of Nevada, Office of the Treasurer," to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within thirty (30) days of the effective date of this Order.

15. Upon approval of this Stipulation by the Board, Respondent CVS shall pay the administrative fee agreed to herein by *cashier's check* or *certified check* or *money order* made payable to "Nevada State Board of Pharmacy," to be received by the Board's Reno office located at 985 Damonte Ranch Parkway – Suite 206, Reno, Nevada 89521, within thirty (30) days of the effective date of this Order;

16. Subject to the approval of this Stipulation by the Board, the Board and Respondent CVS agree to release each other from any and all additional claims arising from the facts set forth in the Accusation on file herein, whether known or unknown that might otherwise have existed on or before the effective date of this Order.

Respondent CVS has fully considered the charges and allegations contained in the *Notice of Intended Action and Accusation* in this matter, and the terms of this Stipulation, and has freely and voluntarily agreed to the terms set forth herein, and waived certain rights, as stated herein.

AGREED:

Signed this ___ day of June, 2019

AUTHORIZED REPRESENTATIVE
CVS Pharmacy #4691
Certificate of Registration No. PH02471

Signed this ___ day of June, 2019

BRETT KANDT, ESQ.
General Counsel
Nevada State Board of Pharmacy

DECISION AND ORDER

The Nevada State Board of Pharmacy hereby adopts the foregoing Stipulation as its decision as to Respondent CVS Pharmacy #4691, Certificate of Registration No. PH02471, in Case No. 18-086-PH-N and hereby orders that the terms of the foregoing Stipulation be made effective upon execution below.

_____
Dated

_____
Jason Penrod, President
Nevada State Board of Pharmacy

5

Pharmacy Board

From: Lisa Hutchins <ljohn116@jhmi.edu>
Sent: Tuesday, April 16, 2019 7:57 AM
To: David Wuest; Pharmacy Board
Subject: Request for Placement on June BOP Meeting Agenda
Attachments: Nevada BOP Meeting Placement Request.pdf

Good morning,

Please see the attached letter with my request to be placed on the June Board Meeting agenda. Thank you for your assistance with this. Please do not hesitate to let me know if any information is needed prior to the meeting and any next steps.

If it is possible to be scheduled on Wednesday, June 5 in the morning, that would be greatly appreciated, however I can be available either day.

Thank you!

Lisa

Lisa M. Hutchins, PharmD, BCPPS
Clinical Pharmacy Specialist, Pediatric Emergency Medicine
Johns Hopkins Children's Center
1800 Orleans Street
Baltimore, MD 21287
ljohn116@jhmi.edu

Lisa Hutchins
Mahogany Drive
North East, MD 21901

April 16, 2019

Nevada Board of Pharmacy
431 W. Plumb Lane
Reno, Nevada 89509

To Whom It May Concern,

I am writing to request placement on the Nevada Board of Pharmacy Meeting agenda in June. This request is regarding approval to work at a site other than a licensed pharmacy in the state of Nevada. I am currently a licensed pharmacist in another state who is completing my application process for licensure in the state of Nevada. I am working with CrowdRx, Inc. who is providing emergency medical services for Burning Man in August and September in Nevada. As this is not a licensed pharmacy, according to state law I must obtain approval to engage in any pharmacy practice at a site other than a licensed pharmacy. I have reviewed the Nevada Administrative Code that lists the necessary information regarding this request. I will be prepared with this requested information in writing for the Board Meeting. I will be working closely with Juliana Zschoche, who obtained approval to work in this location in this capacity last year.

Thank you for your assistance with this request. Please do not hesitate to let me know if any information is needed prior to the meeting and any next steps.

Thank you for your consideration,
Lisa

Lisa Hutchins, PharmD, BCPPS
Clinical Pharmacy Specialist - Pediatric Emergency Medicine
1800 Orleans Street
Baltimore, MD 21287
Office: 410-502-9200
Cell:

6

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,	)	**CASE NOS. 17-038-RPH-S**
	)	
Petitioner,	)	
v.	)	**ORDER**
	)	
NAZALENE ZEBARI, RPH	)	
Certificate of Registration No. 16946	)	
	)	
Respondents.	)	
	/	

This matter came before the Nevada State Board of Pharmacy (Board) at its regularly scheduled meeting on Wednesday, April 11, 2018, in Las Vegas, Nevada. Brett Kandt, Esq., appeared and prosecuted the case before the Board. Respondent Nazalene Zebari, R.Ph. (Zebari), Certificate of Registration 16946, appeared without counsel. The Board heard the case and, based on the evidence presented, the Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

The allegations against Zebari, as stated in the Accusation on file herein, and upon which Zebari admits and the Board makes findings of fact, are as follows:

1. Zebari was a pharmacist registered by the Board, Certificate of Registration 16946, at the time of the events herein.

2. In April 2017, a Walmart Practice Compliance (Walmart) director notified Board Staff that it terminated Zebari from her employment as a pharmacist at Walmart Pharmacy #10-4557. Walmart terminated Zebari's employment for creating a fraudulent prescription for a non-controlled substance for personal use.

3. Zebari admitted that on June 5, 2016, she fabricated and filled a fraudulent "Telephoned Prescription" for herself for Singulair 10 mg. tablets (Prescription No. 6928848).

4. Zebari fabricated the "Telephone Prescription" by falsely documenting Dr. Koussay Zarka as the prescribing physician.

5. Zebari did not have a bona fide patient/practitioner relationship with Dr. Zarka.

6. After being apprised by Walmart of the prescription unlawfully written using his name, Dr. Zarka reviewed a copy of the prescription provided by Walmart. Dr. Zarka signed, dated and documented "not authorized" on the copy of the falsified prescription. He also signed a statement affirming that he did not authorize Prescription No. 6928848 for Zebari.

7. A Walmart Market Director confirmed to the Board Investigator that Zebari paid for the fraudulent prescription by paying the copayment and billing the prescription through her Walmart insurance plan.

8. Zebari did not ingest any of the Singulair tablets. She instead sent the medication to a relative that resides in California. The relative ingested thirty-four (34) tablets.

CONCLUSIONS OF LAW

Based on the forgoing findings of fact, the Board concludes as a matter of law:

9. The Board has jurisdiction over this matter and this respondent, because at the time of the events herein, Zebari was a pharmacist registered by the Board.

10. By creating a fraudulent prescription for a dangerous drug for herself as detailed herein, Zebari, violated NAC 639.945(1)(h).

11. Zebari has never been licensed as a practitioner and has never been authorized to prescribe dangerous drugs in Nevada. By prescribing a dangerous drug for herself, Zebari violated NAC 639.945(1)(h) and (k).

12. By processing a fraudulent prescription (Prescription No. 6928848) for a dangerous drug without a lawful prescription or authorization from a practitioner, and by billing that prescription to an insurance provider, Zebari violated NAC 639.945(1)(h).

13. By furnishing a dangerous drug, namely, Singulair 10 mg. tablets, to another person without a legal prescription, Zebari violated NRS 454.221 and NAC 639.945(1)(h).

14. For each of these violations, Zebari's pharmacist registration, Certificate of Registration 16946, is subject to discipline pursuant to pursuant to NRS 639.210(1), (4), (11) and/or (12), and NRS 639.255.

ORDER

THEREFORE, THE BOARD HEREBY ORDERS AS FOLLOWS:

1. The registration of Respondent Nazalene Zebari, R.Ph., Certificate of Registration 16946, is hereby revoked.

2. Zebari may not work in any facility licensed by the Board, including a pharmacy, in any capacity unless and until she has applied to the Board for reinstatement and the Board reinstates her registration.

3. Zebari may not apply for reinstatement of her registration for a period of one year from the effective date of this Order.

4. In the event Zebari applies for reinstatement, or for any other registration or certificate with the Board, she shall appear before the Board to answer questions and give testimony regarding her application, her compliance with this Order, and the facts and circumstances underlying this matter.

5. Pursuant to NRS 639.251, this Order shall become effective 30 days after receipt by the respondent.

IT IS SO ORDERED.

Entered this 23 day of April, 2018.

Leo Basch, President
Nevada State Board of Pharmacy

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NAZALENE KEMAL ZEBARI,	)	
	)	
Petitioner,	)	
	)	
	)	**CASE NO. 17-038-RPH**
	)	
Certificate of Registration No. 16946.	)	
	)	
_____/		

PETITION FOR RESINSTATMENT OF CERTIFICATE OF REGISTRATION

COMES NOW Petitioner Nazalene Kemal Zebari pursuant to NRS 639.257 and hereby petitions the Nevada State Board of Pharmacy ("Board") for reinstatement of her Certificate of Registration to practice as a pharmacist based on the following.

STATEMENT OF FACTS/PROCEDURAL HISTORY

Ms. Zebari was originally licensed as a registered pharmacist by the Board in July 2006. In 2017 Ms. Zebari was employed by Walmart Pharmacy store #10-4557 in Las Vegas and had been so employed for approximately nine years. In April 2017, Ms. Zebari was terminated from her position at Walmart after it was discovered that in June 2016 she had created a fraudulent telephone prescription under the name of Dr. Koussay Zarka for Singular 10 mg tablets. Ms. Zebari filled the prescription which she subsequently sent to her sister. Ms. Zebari's sister subsequently received a bona vide prescription for Singular from her personal physician.

The Board filed a Notice of Intended Action and Accusation on February 23, 2018 charging Ms. Zebari with four alleged violations of NRS and NAC chapters 639 regarding the creation and filling of the fraudulent prescription. Ms. Zebari filed an Answer and Notice of Defense on March 14, 2018 in which she took responsibility for her conduct. Ms. Zebari appeared before the Board on April 11, 2018 at the time of the hearing on the Accusation. Ms. Zebari again took

responsibility for her actions and apologized for her lapse in judgment. After considering the matter the Board voted to revoke Ms. Zebari's certificate of registration to practice as a pharmacist for a minimum of one year. Ms. Zebari requested reconsideration of the Board's decision and again appeared before the Board on June 7, 2018 after which the Board voted to uphold its previous decision to revoke Ms. Zebari's registration for a period of at least one year.

Ms. Zebari's registration has been revoked since April 11, 2018 and Ms. Zebari now petitions the Board for reinstatement of her certificate of registration to practice as a registered pharmacist pursuant to the Board's order and NRS 639.257.

REQUEST FOR REINSTATEMENT

Ms. Zebari has taken full responsibility for her actions at all times since the commencement of the administrative proceedings against her and continues to do so. As Ms. Zebari presented at the time of the proceedings in 2018, she contacted Dr. Zarka by letter, and attempted by phone, to apologize for her actions, fraudulently creating a prescription under his name. (See Exhibit A) Additionally Ms. Zebari attempted to pay Walmart for the prescription but was unable to successfully do so. Ms. Zebari also presented letters of support from colleagues, Matin Bhatt, Shelly Hausrath, Modupe Irorobeje, Cherole Pils, and Gena Melnik, all of whom are licensed by the Board. (See Exhibit B)

Over the course of the preceding year since the revocation of her license, Ms. Zebari has continued to reflect on her actions and has proactively addressed her lapse of professional judgment giving rise to the action taken by the Board against her certificate of registration. While Ms. Zebari has not held fulltime work over the last year, she has engaged in volunteer work in her community and has taken almost one hundred (100) hours of additional continuing education credits to stay current in the practice of pharmacy. (See Exhibit C) Additionally, Ms. Zebari has attended almost every Board meeting held in Las Vegas since her request for rehearing was denied.

(See Exhibit D) Through her attendance at these meetings Ms. Zebari has gained invaluable knowledge that she believes will serve her well should the Board be inclined to grant her request for reinstatement.

Should the Board grant Ms. Zebari's request for reinstatement, Ms. Zebari is willing to comply with any requests or conditions that the Board deems advisable to place on the reinstatement of her registration. Ms. Zebari notes that she does not intend on returning to practice as a registered pharmacist on a full-time basis immediately if her registration is reinstated, but rather would like to reintegrate herself into the profession by working a few days per week.

CONCULSION

The revocation of Ms. Zebari's certificate of registration to practice as a pharmacist has had a profound impact on her life not only professionally, but personally. She continues to take responsibility for her profound lack of professional judgment and assures the Board that such a lapse was a one-time occurrence and that she will be diligent in ensuring that she remains in strict compliance with all professional and ethical obligations that the reinstatement of her registration would require of her. She respectfully requests that this Board reinstate her registration as a pharmacist so that she may return to practicing in her chosen profession to provide professional and compassionate assistance to patients.

Respectfully submitted this 14th day of May, 2019.

Lyn E. Beggs, Esq.
Attorney for Petitioner

Approved as to form and content:

Nazalene Kemal Zebari

EXHIBIT A

COPY

To Dr. Zarka,

I am writing this letter to offer my sincerest apologies. I am sure you aware of the situation, but I am admitting that last year, I used your name to write a prescription for myself for Singulair. I understand that what I did was ethically wrong and I took advantage of your kindness and abused my position as a pharmacist when this occurred. You have been so generous and good-hearted and betraying you this way is an insult to all the nice things you've done for me. I deeply regret my actions and take full responsibility for them. I don't expect your forgiveness, but I do hope what I've done does not alter your opinion of the pharmacy profession. Please accept my genuine remorse.

Sincerely,

Nazalene Zebari

Copy:
This was mailed to address:
1 Picasso Cir
Las Vegas, NV 89121
Left a message at number:
on May 1st 2017

EXHIBIT B

4/9/2018

To the Members of the Nevada Board of Pharmacy :

I have known Nazalene Zebari professionally for over 6 years and in that time she has only shown kindness, empathy, and genuine compassion for her patients. The issue(s) that have led to her having to appear before the NV-BOP are very uncharacteristic of the person that I have known for so long. First and foremost, a lapse in judgement was made and for that there are consequences. However, if one was to carefully analyze/review her entire 12 year career as a retail pharmacist, I am quite certain that there would be no other questions regarding her character or integrity.

Again, this was certainly a lapse in both judgement and professionalism, but I do deeply believe it was a one time lapse only and that it is truly not indicative of this person. Nazalene, is the primary financial provider for her 3 children and one of whom is set to start college shortly. This situation has impacted her tremendously and she feels a great deal of remorse and regret not only professionally but more so personally with her family. She has been very honest and accountable and I have no doubt that nothing of this nature will ever present itself again.

Throughout my career, I have been asked by various people to write recommendation letters. However, I only have written them for people I truly believe in and am not afraid to decline. When I was asked by Nazalene, I had no hesitation whatsoever. I know that good people can sometimes make uncharacteristic mistakes and I genuinely feel that she is a good person and a great pharmacist. I ask that you take all these things into account and give her the chance to keep working to both redeem herself and to continue to support her family. Thank you for your time and consideration.

Sincerely,

Matin R. Bhatt

Shelley R. Hausrath
Casa Monica Ct
Las Vegas, NV 89141

April 2, 2018

To Whom It May Concern,

I am writing in reference to Nazalene Zebari to whom I have personally known as a friend and colleague for 15 years.

I first met Nazalene in pharmacy school in 2003, and what impressed me the most was her kindness, warm heart, and her compassion for others. She always presents herself with levelheadedness and grace. It didn't take me very long to know that I wanted to be friends with her. During my relationship with Nazalene, I have experienced an individual who shows up earlier than asked, works hard, and carries herself in a polite, respectable manner. In addition, she is a family-person who always puts others above herself. You can always depend on her in a time of need. She will drop everything and be by your side in a moment's notice. I am truly honored to know such a great person that has such a strong ethical sense, a high degree of integrity and responsibility, and always maintains good moral character.

It is my sincere hope that this letter is taken into consideration at the time of sentencing. Despite the current case, I still believe Nazalene Zebari to be an honorable individual, a valuable member of our community, and a good human being. Please do not hesitate to contact me if you should require any further information.

Sincerely,

Shelley R. Hausrath

Providence Pharmacy
1729 E Charleston Blvd # F• Las Vegas, 89104 • P: 702-778-3072 • F: 702-778-0512

April 9, 2018

To whom it may concern,

This letter serves to verify and certify that Nazalene Zebari is a friend and coworker. I have known Nazalene for seven years and worked with her at Walmart. She also currently works at my independently owned Pharmacy per diem. Naz came to me after she was terminated from Walmart seeking employment and was straightforward and honest about her situation. I know her to be caring, professional, and trustworthy and hard working. She continues to work for us on an as needed basis and is willing to pick up any shift to support her family. She is very helpful, great with patients and reliable. I know she can't take back what she has done but she is a good person and loves working in the pharmacy field. I hope this letter helps in the determination of Naz's case.

Thank you
Respectfully,
Irorobeji
Pharmacy Manager
Modupe Irorobeje.

March 9, 2018

Nevada Pharmacy Board Member's:

Re: Nazalene Zebari

Dear Board Members,

My name is Cherole Pils and I have known Nazalene Zebari for the last 5 years. She has been my friend as well as a work colleague. Nazelene is truly a great pharmacist, she loves people, truly cares about their well-being and is always willing to listen to patients problems in their life unrelated to their medications. She is truly a "people person". Nazalene is very good at counseling patients, she has an amazing ability to ask the right questions to get patients to talk about themselves and find out any underlining issues that might be affecting their wellbeing or quality of life. She would often have patients bring in all of their medications and go over them 1 by 1 to see how they were doing on the medication and if they were having problems on specific ones. She is a very thorough and precise Pharmacist, double and triple checking Rx's that needed extra attention. She would often work extra shifts at other pharmacies to help them out when the needed arose.

Nazalene or "Naz" as her friends know her is a true and fast friend. She is fiercely loyal and also a very forgiving friend. If someone needs a sounding board for ideas she is always there offering her opinion and being your cheerleader. Naz often picked up one of the technicians that was having a lot of car problems so she could make it to work on time. She in the past had offered one of our tech's a place to stay when their house wasn't ready to be moved in yet. I hope I've given you a brief overview of Nazalene's character as well as many assets she brings to the Pharmacy profession.

Respectfully,

Cherole Pils

April 5, 2018

To whom it may concern,

My name is Gena Melnik and I am a pharmacy manager at Wal-Mart. This letter is my personal character reference for Nazalene Zebari. I have known Nazalene for 3 years and she has displayed an admirable sense of dedication to her job, where she leaves no stones unturned when it comes to tasks assigned to her. Her professional ethics has surpassed my initial expectations of her and she is one of my most dependable team player. She is able to work efficiently with or without supervision and I can rely on her to make sure the job is done. She has built good relationships with her patients that she has become the "go-to" person to help them solve their health needs.

Like any other parent of 3 beautiful kids, she has mastered the art of time management, where her responsibilities at home are not a hindrance to her excellent performance at work.

Nazalene will be a great asset to any organization. I therefore offer my highest recommendation for Nazalene to future employers who will be lucky to have her on their team.

Sincerely,

Gena Melnik
Pharmacy Manager

EXHIBIT C

Therapeutic Research Center confirms that
Nazalene Zebari, Doctorate of Pharmacy license has successfully completed the courses below:

State: Nevada

Renewal Period: 11/1/2017 - 10/31/2019 cb1e9fb0-2c28-449d-9b90-7894a323f13c

Course Title & CE Provider	Date Completed	Contact Hours	Requirements Met
Respecting Patients' End-of-Life Care Wishes: End-of-Life Care Planning and Palliative Pain Management ACPE#: JA0006454-0000-18-775-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	2.00	General CE
Strategies for Communicating Effectively with Patients ACPE#: JA0006454-0000-18-782-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Tackling a Growing Problem: Childhood Obesity ACPE#: JA0006454-0000-18-050-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/26/19	1.00	General CE
Disaster Preparedness & Emergency Response: The Role of the Pharmacist ACPE#: JA0006454-0000-18-792-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Cultural Competence: Care of the LGBTQ Patient ACPE#: JA0006454-0000-18-399-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	11/08/18	2.00	General CE
The Art of Selecting & Prescribing Hormonal Contraception ACPE#: JA0006454-0000-18-793-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/26/19	1.00	General CE
Reproductive Health Issues for Women ACPE#: JA0006454-0000-18-794-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/09/19	1.00	General CE
Travel Medicine: Passport to Staying Healthy During International Travel ACPE#: JA0006454-0000-18-798-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	09/17/18	2.00	General CE
A Review of DEA Requirements ACPE#: JA0006454-0000-18-051-H03-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	09/29/18	1.00	General CE
Safe Use of Opioids ACPE#: JA0006454-0000-18-007-H05-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/26/19	1.00	General CE
Pharmacist's Guide to Osteoporosis ACPE#: JA0006454-0000-18-018-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Resolving and Reducing Conflict and Violence in the Pharmacy ACPE#: JA0006454-0000-18-055-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/28/19	1.00	General CE
Diabetes Care ACPE#: JA0006454-0000-18-060-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/28/19	1.00	General CE
The Ins and Outs of Generic Substitution ACPE#: JA0006454-0000-18-057-H03-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/26/19	1.00	General CE
HIV/AIDS Prevention and Management ACPE#: JA0006454-0000-18-035-H02-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Pharmacy Leadership: Developing Leadership Skills ACPE#: JA0006454-0000-18-073-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/28/19	1.00	General CE
Controlled Substances in West Virginia: Best Practices in Prescribing and Preventing Diversion ACPE#: JA0006454-0000-18-040-H03-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	3.00	General CE
Preventing Medication Errors ACPE#: JA0006454-0000-18-072-H05-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	2.00	General CE

Managing Up: Improving Work Relationships ACPE#: JA0006454-0000-18-075-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/28/19	1.00	General CE
Controlled Substances: Preventing Diversion and Promoting Patient Safety with Opioids ACPE#: JA0006454-0000-18-042-H05-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	2.00	General CE
Empathy in the Pharmacy Setting: Strategies for Providing Empathetic Care ACPE#: JA0006454-0000-18-308-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/28/19	1.00	General CE
Controlled Substance Prescriptions: Balancing Access and Diversion Prevention ACPE#: JA0006454-0000-18-218-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	2.00	General CE
Naloxone Rescue Therapy for Opioid Overdose ACPE#: JA0006454-0000-18-213-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	10/11/18	2.00	General CE
Medication Adherence: What You Need to Know ACPE#: JA0006454-0000-18-223-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	1.00	General CE
Drug Therapy Review for HIV/AIDS ACPE#: JA0006454-0000-18-210-H02-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	09/26/18	2.00	General CE
Federal Pharmacy Law ACPE#: JA0006454-0000-18-314-H03-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	10/09/18	1.00	General CE
Attention-Deficit / Hyperactivity Disorder: ADHD ACPE#: JA0006454-0000-18-214-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/09/19	1.00	General CE
Acne ACPE#: JA0006454-0000-18-337-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Embracing Cultural Competence and Improving Cultural Communications ACPE#: JA0006454-0000-18-313-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/09/19	1.00	General CE
Managing Chronic Opioid Patients in the Community Pharmacy Setting ACPE#: JA0006454-0000-18-225-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	1.00	General CE
Burn Injury and the Impact on Pharmacokinetics ACPE#: JA0006454-0000-18-232-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Travel Medicine: Passport to Healthy and Safe International Travel ACPE#: JA0006454-0000-18-246-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	2.00	General CE
A Guide to the 2018-2019 Influenza Season Recommendations ACPE#: JA0006454-0000-18-243-H06-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	1.00	Immunization CE
Influenza Vaccination for Special Populations ACPE#: JA0006454-0000-18-244-H06-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	1.00	Immunization CE
The Pharmacy Team's Role in Ensuring Appropriate Use of Live Vaccines ACPE#: JA0006454-0000-18-327-H06-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/06/19	1.00	Immunization CE
Recognizing and Reporting Child Abuse in Pennsylvania ACPE#: JA0006454-0000-18-326-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	2.00	General CE
The Pharmacy Team's Role in the Management of Dementia ACPE#: JA0006454-0000-18-328-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE
Motivational Interviewing to Promote Change ACPE#: JA0006454-0000-18-247-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/28/19	1.00	General CE

Suicide Assessment, Prevention, and Intervention ACPE#: JA0006454-0000-18-262-H04-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	3.00	General CE
Counseling Patients with Type 2 Diabetes ACPE#: JA0006454-0000-19-203-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/09/19	1.00	General CE
New Drugs Available in 2018 ACPE#: JA0006454-0000-19-206-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/26/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care October 2017 ACPE#: 0422-0000-17-010-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	08/16/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care November 2017 ACPE#: 0422-0000-17-711-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	08/24/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care December 2017 ACPE#: 0422-0000-17-012-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	08/29/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care January 2018 ACPE#: 0422-0000-18-701-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	08/29/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care February 2018 ACPE#: 0422-0000-18-702-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	08/29/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care March 2018 ACPE#: 0422-0000-18-703-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care: April 2018 ACPE#: JA0006454-0000-18-704-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care May 2018 ACPE#: JA0006454-0000-18-705-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care June 2018 ACPE#: JA0006454-0000-18-706-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/17/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care July 2018 ACPE#: JA0006454-0000-18-707-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care August 2018 ACPE#: JA0006454-0000-18-708-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	09/17/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care September 2018 ACPE#: JA0006454-0000-18-709-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	09/17/18	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care October 2018 ACPE#: JA0006454-0000-18-710-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into Patient Care November 2018 ACPE#: JA0006454-0000-18-711-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/06/19	1.00	General CE
Emerging Developments in Drug Therapy and Implementation into	01/06/19	1.00	General CE

Patient Care December 2018 ACPE#: JA0006454-0000-18-712-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)			
Pharmacist's Letter CE-in-the-Letter January 2019 ACPE#: JA0006454-0000-19-701-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	01/06/19	1.00	General CE
Pharmacist's Letter CE-in-the-Letter February 2019 ACPE#: JA0006454-0000-19-702-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	02/11/19	1.00	General CE
Pharmacist's Letter CE-in-the-Letter March 2019 ACPE#: JA0006454-0000-19-703-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	03/19/19	1.00	General CE
Pharmacist's Letter CE-in-the-Letter April 2019 ACPE#: JA0006454-0000-19-704-H01-P cb1e9fb0-2c28-449d-9b90-7894a323f13c (printed previously)	04/02/19	1.00	General CE

and is awarded 74.00 total Contact Hours

In support of improving patient care, Therapeutic Research Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Tammie Armeni, RPh, PharmD April 26, 2019

US-licensed Pharmacists/Technicians: This certificate is supplied as a courtesy to our participants. Official Statements of Credit are only available through CPE Monitor.

These courses are sponsored by Therapeutic Research Center
3120 W. March Lane, Stockton, CA 95219
TEL: (209) 472-2240 FAX: (209) 472-2249

Print

Close Window

PEER

PHARMACY ETHICS, EDUCATION, & RESOURCES

Certificate of Achievement

Presented to:
Nazalene Zebari

by Pharmacy Ethics Education, and Resources (PEER)

Test name: Priority of Pharmacy Ethics in Healthcare-Module 1
Score: 75% (9 out of 12)

Priority of Pharmacy Ethics in Healthcare Online Course, a knowledge-based course, has been approved for 1 contact hour (0.1 CEU) of continuing education credit obtained in the home study with ACPE Universal Activity Numbers 0201-9999-16-057-H04 P/T.

Tue 10th Apr 2018

The American College of Apothecaries (ACA) is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. All sessions carrying the ACPE program number are approved for continuing education credit.

PEER

PHARMACY ETHICS, EDUCATION, & RESOURCES

Certificate of Achievement

Presented to:
Nazalene Zebari

by Pharmacy Ethics Education, and Resources (PEER)

Test name: Evolution of Healthcare Ethics-Module 2
Score: 90% (9 out of 10)

Evolution of Healthcare Ethics Online Course, a knowledge-based course, has been approved for 1 contact hour (0.1 CEU) of continuing education credit obtained in the home study with ACPE Universal Activity Numbers 0201-9999-16-058-H04 P/T.

Wed 10th Apr 2019

freeCE.com
PHARMACEUTICAL EDUCATION CONSULTANTS

STATEMENT OF CREDIT

Nazalene Zebari

CPE Monitor ID: **135134**

Pharmacy Law vs. Pharmacy Ethics

Accreditation Number: **0798-0000-17-167-H03-P**
Activity Type: **Knowledge**
Date Completed: **Tuesday, April 10, 2018**

This activity has been approved for 1 contact hour(s) of continuing education for Pharmacists.

PharmCon, Inc. is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Kevin Hope, RPh
Continuing Education Administrator

Signed and issued on: **4/10/2018**

PHARMACEUTICAL EDUCATION CONSULTANTS, INC. PHARMCON 1990

This Statement of Credit will be retained online by freeCE for a minimum of five (5) years.

PharmCon | 1404-A Main Street | Conway, SC 29526 | (843) 488-5550 | www.freece.com

Certificate of Completion

The

California Board of Pharmacy

2018 Pharmacy Law Continuing Education Course

1 Hour tutorial

Print and keep this certificate for your records

Enter Your Name	Nazalene Zebari
Select License Type	Pharmacist / Nevada
Enter License #	16946
Enter Your Email	nazalene.z@yahoo.com

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

CALIFORNIA STATE BOARD OF PHARMACY
BE AWARE AND TAKE CARE: Talk to your pharmacist!

1/19/2019

Introduction to Homeopathic Medicine for the Pharmacy Professional

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

Only learners who provided valid NABP e-Profile ID numbers and PIN numbers (month and day of birth) in their registration information will be submitted to ACPE/NABP's CPE Monitor for official record of credit. Pharmacy learners who do not provide this information will not be eligible to receive credit.

You can access your CPE Monitor Account through the NABP website link:https://nabp.pharmacy/cpe-monitor-service/ or contact NABP Customer Service at (847) 391-4406.

Sincerely,
Power-Pak C.E.

1/19/2019

Beyond Fiber and Laxatives: Advising Patients with Chronic and Refractory Constipation-Article

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

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Sincerely,
Power-Pak C.E.

1/19/2019

How Specialty Pharmacists Can Enhance Patient-Driven Care in Multiple Sclerosis

Dear Nazalene Zebari

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Sincerely,
Power-Pak C.E.

1/18/2019

Itching to Improve Allergic Rhinitis Management?
Tips for Patient Care

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

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You can access your CPE Monitor Account through the NABP website link:https://nabp.pharmacy/cpe-monitor-service/ or contact NABP Customer Service at (847) 391-4406.

Sincerely,
Power-Pak C.E.

1/18/2019

Caring For Cold Sores In The Community Pharmacy

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

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Sincerely,
Power-Pak C.E.

1/18/2019

Targeting Underserved Populations for Diabetes Screening and Education

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

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Sincerely,
Power-Pak C.E.

1/18/2019

Acetaminophen-Induced Hepatotoxicity: The Pharmacist's Role in Prevention and Treatment

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

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Sincerely,
Power-Pak C.E.

1/18/2019

Caring for Contact Lenses: A Guide for the Pharmacist

Dear Nazalene Zebari

You have successfully completed the post-test and evaluation for the above-named activity. A record of your participation and verification of credit will be maintained with the accredited provider and a record of successful completion of this activity will be submitted to ACPE/NABP's CPE Monitor. You may look for your statement of credit to appear in your CPE Monitor account in approximately 1 week.

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Sincerely,
Power-Pak C.E.

EXHIBIT D

NEVADA STATE BOARD OF PHARMACY
CERTIFICATE OF CONTINUING EDUCATION

DATED JUL 18 2018

Nazalene Zebari WAS IN ATTENDANCE AT THE NEVADA STATE BOARD OF PHARMACY MEETING HELD IN LAS VEGAS,

3 ACCREDITED HOURS OF CE WAS EARNED.
1 ACCREDITED HOUR OF LAW CE WAS EARNED.

LARRY L. PINSON, PHARM.D

YOU MUST MAINTAIN THIS CERTIFICATE AND ONLY PROVIDE IF AUDITED.

THE BOARD OF PHARMACY OFFICE DOES NOT HAVE A COPY AND CAN NOT PROVIDE A COPY IF YOU ARE AUDITED.

NEVADA STATE BOARD OF PHARMACY
CERTIFICATE OF CONTINUING EDUCATION

DATED OCT 1 1 2018

Nazalene Zebari WAS IN ATTENDANCE AT THE NEVADA STATE BOARD OF PHARMACY MEETING HELD IN LAS VEGAS,

3 ACCREDITED HOURS OF CE WAS EARNED.
1 ACCREDITED HOUR OF LAW CE WAS EARNED.

LARRY L. PINSON, PHARM.D

YOU MUST MAINTAIN THIS CERTIFICATE AND ONLY PROVIDE IF AUDITED.

THE BOARD OF PHARMACY OFFICE DOES NOT HAVE A COPY AND CAN NOT PROVIDE A COPY IF YOU ARE AUDITED.

Nevada State Board of Pharmacy
Certificate of Continuing Education

Date: JAN 1 6 2019 KS

Nazalnae Zobari was in attendance at the
Nevada State Board of Pharmacy meeting held in Las Vegas, Nevada.

3 accredited hours of CE was earned.
1 accredited hour of law was earned.

J. David Wuest, R.Ph.
Executive Secretary

You must maintain this certificate and only provide a copy if audited.
The Board of Pharmacy office does not have a copy and cannot provide a copy if you are audited.

Nevada State Board of Pharmacy
Certificate of Continuing Education

Date: JAN 17 2019

Nazaleen Zebari was in attendance at the Nevada State Board of Pharmacy meeting held in Las Vegas, Nevada.

3 accredited hours of CE was earned.
1 accredited hour of law was earned.

J. David Wuest, R.Ph.
Executive Secretary

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The Board of Pharmacy office does not have a copy and cannot provide a copy if you are audited.

Nevada State Board of Pharmacy
Certificate of Continuing Education

Date: APR 1 0 2019

Nazalene Zebari was in attendance at the
Nevada State Board of Pharmacy meeting held in Las Vegas, Nevada.

3 accredited hours of CE was earned.
1 accredited hour of law was earned.

J. David Wuest, R.Ph.
Executive Secretary

You must maintain this certificate and only provide a copy if audited.
The Board of Pharmacy office does not have a copy and cannot provide a copy if you are audited.

Nevada State Board of Pharmacy
Certificate of Continuing Education

Date: APR 1 1 2019 KS

Nazalene Zobari was in attendance at the
Nevada State Board of Pharmacy meeting held in Las Vegas, Nevada.

3 accredited hours of CE was earned.
1 accredited hour of law was earned.

J. David Wuest, R.Ph.
Executive Secretary

You must maintain this certificate and only provide a copy if audited.
The Board of Pharmacy office does not have a copy and cannot provide a copy if you are audited.

7

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☑ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: One Choice Pharmacy

Physical Address: 2503 S. Main, Ste. D Stafford TX 77477

Mailing Address: 2503 S. Main Ste. D

City: Stafford State: TX Zip Code: 77477

Telephone: 281-969-7899 Fax: 346-341-7968

Toll Free Number: 800-505-1327 (Required per NAC 639.708)

E-mail: onechoicepharmacy@gmail.com Website: N/A

Managing Pharmacist: Gerald E. Zimmerman License Number: 30404

TYPE OF PHARMACY AND		SERVICES PROVIDED	
Yes/No		Yes/No	
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral **
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☑	☑ Community	☐	☑ Long Term Care
☑	☐ Other: NON-RESIDENT	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
All boxes must be checked		☐	☑ Mail Service Sterile Compounding **
For the application to be complete		☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Gerald E. Zimmerman / PIC
Print Name of Authorized Person

2/2/2019
Date

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: Universal Healthcare Network, LLC

Business Name: One Choice Pharmacy

Current Business Address: 2503 S. Main, Ste. O

City: Stafford State: TX Zip Code: 77477

Telephone: 281-969-7899 Fax: 346-341-7968

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 5 pm Saturday 9 am 3 pm

Sunday closed pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: _____

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Gerald E. Zimmerman

Responsible Person of One Choice Pharmacy

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Gerald E. Zimmerman / PIC

Print Name of Authorized Person

2/7/2019

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF TEXAS)
) ss.
Harris COUNTY)

I, Gerald E. Zimmerman, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Pharmacist in charge for One Choice Pharmacy (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Gerald E. Zimmerman, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
7th day of February, 2019.

Sonia K Trevino
NOTARY PUBLIC EXP: 5/19/19

SONIA KATERI TRE
Notary Public, State
My Commission E
May 19, 20

SONIA KATERI TREVINO
Notary Public, State of Texas
My Commission Expires
May 19, 2019

ONE CHOICE Pharmacy

RE: Pharmacy Staff List

Owned by Entity:

Universal Healthcare Network LLC
2503 S. Main Street, Ste O
Stafford, TX 77477
FEIN: 82-190548

Corporate Officer:

Fathy ElSafty
Windsor Lakes Dr.
Houston, TX 77094
DOB: 9
SSN:

Pharmacist In Charge

Gerald Zimmerman
_____ Gondola Dr
Stafford, TX 77477
DOB:

ONE CHOICE Pharmacy

Re: Non-Resident Pharmacy License Application

Universal Healthcare Network LLC (dba) One Choice Pharmacy is a retail/non-resident pharmacy that dispenses diabetic testing supplies and a handful of topical ointments, creams & gels. One Choice Pharmacy does not participate in Compounding Medications and does not dispense any Controlled Substances. If the pharmacy dispensing should change in any manner, all state board of pharmacies will be immediately notified.

For additional questions or concerns please email:

Onechoicepharmacy@gmail.com

2503 S. Main Street, Ste. O, Stafford, TX 77477 | TF: 1-800-505-1327 | Fax: 346-341-7968

This certifies that the pharmacy named below is hereby licensed to operate as a Class **A** pharmacy.

License No. **31986** Expiration Date: **4/30/2020**

Balances: **0**

ONE CHOICE PHARMACY
2503 S MAIN STE O
STAFFORD TX 77477

Allison Vordenbaumen Benz, R.Ph., M.S.
Executive Director/Secretary

MUST BE DISPLAYED IN FULL PUBLIC VIEW

TEXAS STATE BOARD OF PHARMACY

Re:	One Choice Pharmacy
Address:	2503 South Main, Suite O Stafford, Texas 77477
License No.:	31986
Date Issued:	April 19, 2018
Licensure Status:	Active
Expiration Date:	April 30, 2020
Type of Pharmacy:	Community – Class A
Prior Disciplinary Orders:	No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. One Choice Pharmacy (Texas Pharmacy License #31986) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

Megan G. Holloway

Megan G. Holloway
Assistant General Counsel
Texas State Board of Pharmacy

April 8, 2019
Date

The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49th Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

8

8A

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b ☐ Partnership - Pages 1,2,6,10,11a&b

☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b ☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: CMH Pharmacy, LLC

Physical Address: (TBD) Making 1930 Village Center Cir. 3-104

City: Las Vegas State: NV Zip Code: 89134

Telephone: 702-400-3139 Fax: N/A

Toll Free Number: N/A E-mail: RLively@cmhmail.com

Website: TBD

Managing Pharmacist: Alysha McMahon License Number: 18590

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral
☑	☐ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☑	☐ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding
	For the application to be complete	☐	☑ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Robert L Lively Jr.
Original Signature of Person Authorized to Submit Application, no copies or stamps

ROBERT L LIVELY JR
Print Name of Authorized Person

12/12/2018
Date

Board Use Only	Date Processed: _____	Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

Type of Partnership: General _____ Limited X

List names of 4 largest partners and percentage of ownership:

Name: ROBERT LEE LIVELY JR. %: 100

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: CMH PHARMACY, LLC

Mailing Address: 1930 VILLAGE CENTER CIRCLE 3-104

City, State Zip Code: LAS VEGAS, NV 89134

Telephone Number: 702-400-3179 Fax Number: N/A

Contact Person: ROBERT LIVELY

List any physician shareholders and percentage of ownership.

Name: NONE %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday _____am _____pm Saturday _____am _____pm

Sunday _____am _____pm 24 Hours X

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20181866473

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, ROBERT L LIVELY JR.

Responsible Person of CMH PHARMACY, LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

ROBERT L LIVELY JR.
Print Name of Authorized Person

12/12/2018
Date

Managing Pharmacist

Pharmacist Name: Alysha McMahon License #: 18590

Pharmacy Name: CMH Pharmacy, LLC

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☒
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☒
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Signature

12/11/18
Date

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE for a Pharmacy or Wholesaler located in Nevada

Date 12/11/18

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 Pharmacy
(Nature of Pharmacy or Wholesaler)

CMH Pharmacy, LLC 1930 Village Center Circle Suite 3-104 Las Vegas NV 89134
(Name and Address of Business for Which Designated Representative Is Requested)

N/A
(If applicable, Name Under Which It Is Now Operated)

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
McMahon	Alysha	Leilani

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise): N/A

Present Residence Address-Street or RFD	City	State/Zip
Pro Tour Ct	Las Vegas	NV 89141

Present Business Address	Dates	City	State/Zip
350 W. Lake Mead Pkwy	8-8-13 to present	Henderson	NV 89015

Present Position with the Pharmacy or Wholesaler	Dates
Pharmacist	8-8-13 to Present

Phone: Residence ____ Business CVS

Date of Birth	Place of Birth (City, County, State)
29	Honolulu, Honolulu, HI

Age	Social Security Number	Sex
		Female

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Green	Brown	Fair	140	Athletic	5'4

Scars, tattoos or distinguishing marks and/or characteristics round scar above right knee

Are you a citizen of the United States? Yes ☒ No ☐ If alien, registration No N/A

If naturalized, certificate No N/A Date N/A

Place N/A (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial all

MARITAL INFORMATION-Continued

A. **Current Marriage** 7/4/18 (Date) Las Vegas, Clark, NV (City, County and State)

Spouse's full name (Maiden) Dustin Lively S.S. No.

Date of Birth Place of Birth Las Vegas, NV

Resident address Pro Tour Ct (Street) Las Vegas (City) NV (State) 89141 (Zip)

Telephone: Residence Business 702-793-1537

Spouse's employer Lennar Occupation construction manager

Address of employer 9275 West Russel Rd (Street) Las Vegas (City) NV (State) 89148 (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
N/A				
N/A				
N/A				

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

Name	Street	City	State	Zip	Telephone
N/A					
N/A					
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
N/A			
N/A			
N/A			

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 AU

FAMILY INFORMATION-Continued

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

Name N/A

Address N/A

Contact person N/A

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Chris McMahon		1 Lloyd George Dr Henderson NV 89052	Corporate Business Consultant
Mother	Susan McMahon		1 Lloyd George Dr Henderson NV 89052	Retired
Father-in-Law	Robert Lively		3 Conough Lane Las Vegas NV 89149	Real Estate Developer
Mother-in-Law	Kelley Clifton		3 Conough Lane Las Vegas NV 89149	Real Estate Developer

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
	Melissa McMahon		Tomessa St Las Vegas NV 89141	Nurse (RN)
Spouse	Chris Holmes		Tomessa St Las Vegas NV 89141	Personal Trainer
	N/A			
Spouse	N/A			
	N/A			
Spouse	N/A			
	N/A			
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	St. John Vianney	920 Keolu Dr. Kailua HI 96734	8/1/94 – 5/30/03	Yes ☒ No ☐
High School	Le Jardin Academy	917 Kalaniana'ole Dr. Kailua HI 96734	8/1/03 - 5/27/07	Yes ☒ No ☐
College University	University of Nevada, Reno	1664 N. Virginia St Reno NV 89557	8/1/07 - 6/1/10	Yes ☐ No ☒
Other	Roseman University	11 Sunset Way Henderson NV 89014	8/1/10 - 6/7/13	Yes ☒ No ☐

Type of degree obtained, if any Doctor of Pharmacy, PharmD

College or university where obtained Roseman University

Applicant's initial AM

5 MILITARY INFORMATION:

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

Branch N/A Date of entry-active service N/A

Date of separation N/A Type of discharge N/A

Rating at separation N/A Serial number N/A

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☒ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☐ No ☒

County N/A State N/A Date registered N/A

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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. List all cases without exception.

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

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes. furnish details on page 10.

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? N/A city, county and state N/A

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

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date
N/A				
N/A				
N/A				

Applicant's initial ALL

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. List all cases without exception, including bankruptcies:

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

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:

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

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
6/89 - 8/07	1422 AuAuki St	Kailua	HI
8/07 - 6/10	2800 Enterprise Rd	Reno	NV
6/10 - 6/16	924 Lloyd George Dr	Henderson	NV
6/16 - 6/18	6482 Holland Hills St	Las Vegas	NV
6/18 - current	, Pro Tour Ct	Las Vegas	NV

Applicant's initial _____

8. EMPLOYMENT:

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

8/13	CVS 350 W. Lake Mead Pkwy Henderson NV 89015	10,000
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Pharmacist, Staff Float, Full Time	Prepare, process, check, counsel dispense medication/prescriptions	Mike Natale
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial ____________

9. 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 Laura Hook	Home	1 Auulu St Kailua HI 96734				25
Employer Student (MD)	Business	University of Hawaii Manoa				
Name Keegen Walsh	Home	5 N. University Blvd Mobile AL 36688				8 10
Employer Student (PA)	Business	University of South Alabama				
Name Cheryl Sherman	Home	1 Awinala Rd Kailua HI 96734				29
Employer The Green Comb	Business	1297 Kapiolani Blvd Honolulu HI 96814				
Name Robin Taber	Home	Wind Drift Boca Acton FL 33433				29
Employer Florida Atlantic University	Business	777 Glades Rd Boca Raton FL 33431				
Name Robert Handley	Home	2 Holland Hills St Las Vegas NV 89113				5
Employer Smith's Nephew	Business	3945 W. Reno Ave Las Vegas NV 89118				

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 Doctor of Pharmacy, Nevada

Licensed 8/8/13 - present

11. Have you ever applied for a city, county of 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.

N/A

N/A

N/A

12. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

N/A

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

N/A

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

N/A

Applicant's initial _____

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 ☒

N/A

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 ☒

N/A

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/or controlled substances? Yes ☐ No ☒

N/A

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 close of a wholesaler Yes ☐ No ☒

N/A

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒

N/A

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler? Yes ☒ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☒ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes ☒ No ☐

Date of photograph 12/7/18

Applicant's initial ac

STATE OF Nevada

ss.

COUNTY OF Clark

I, Alysha McMahon, 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 case for denial or revocation of a wholesaler 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 [H]as 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 of fraudulent, [a]nd further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

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 wholesaler in the State of Nevada.

Original Signature of Applicant

State of Nv. County of Clark

Subscribed and Sworn to before me this 11 day of December 2018

by Alysha L. McMahon

Notary Public

(seal)

D. SAN JUAN
Notary Public - State of Nevada
County of Clark
APPT. NO. 05-93941-1
My App. Expires Dec. 1, 2020

Applicant's initial

ADDITIONAL INFORMATION

Applicant(s) initial _____

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/12/2018

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 PHARMACY
Nature of License

CMH PHARMACY, LLC 1930 VILLAGE CENTER CIR. 3-104 LAS VEGAS, NV 89134
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
LIVELY JR	ROBERT	LEE

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

NONE

Present Residence Address-Street or RFD	City	State/Zip
CONOUGH LANE	Dates 2005 - PRESENT LAS VEGAS	NV 89149
Present Business Address	**City**	**State/Zip**
4105 REMPART Blvd STE 390	Dates 2010 - PRESENT LAS VEGAS	NV 89145

Occupation

Phone:
Residence .....
Business 702-583-6188

Date of Birth	Place of Birth (City, County, State)	
	CRESCENT CITY, DEL NORTE, CALIFORNIA	
Age	**Social Security Number**	**Sex**
57		MALE

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
BROWN	BROWN	FAIR	185	AVERAGE	5'10"

Scars, tattoos or distinguishing marks and/or characteristics CROSS TATTOO LEFT UPPER ARM

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 .....

MARITAL INFORMATION-Continued

A. **Current Marriage** MAY 2, 1981 (Date) LAS VEGAS, CLARK, NV (City, County and State)

Spouse s full name (Maiden) KELLEY-JAY CLIFTON S.S. No.

Date of Birth , , Place of Birth TUCSON, AZ

Resident address, 7 CONOUGH LANE (Street) LAS VEGAS (City) NV (State) 89149 (Zip)

Telephone: Residence, Business 702-583-6188

Spouse s employer BETTER BUILDING TECHNOLOGIES Occupation REAL ESTATE DEVELOPER

Address of employer 410 S. RAMPART BLVD STE 390 (Street) LAS VEGAS (City) NV (State) 89145 (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
NONE				

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

Name	Street	City	State	Zip	Telephone
NONE					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
ROBERT RUSSELL LIVELY	?	LAS VEGAS, NV	9 VALLEY EDGE CT. LAS VEGAS, NV 89141
DUSTIN LEE LIVELY	?	LAS VEGAS, NV	? ARTOUR CT LAS VEGAS, NV 89141
ASHLEY JAY LIVELY	1	LAS VEGAS, NV	7 CONOUGH LANE LAS VEGAS, NV 89149

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

FAMILY INFORMATION-Continued

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

Name.....

Address.....

Contact person.....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	ROBERT LEE LIVELY SR.		PEACEFUL POND LAS VEGAS, NV 89131	SELF-EMPLOYED
Mother	DOROTHY JEAN LIVELY (RYDER)		PEACEFUL POND LAS VEGAS, NV 89131	SELF-EMPLOYED
Father-in-Law	JAMES JAY CLIFTON		GRANADA AVE LAS VEGAS, NV 89107	FLOORING INSTALLER
Mother-in-Law	NANCY LOUISE DAY		CELITA LAS VEGAS, NV 89143	CLERICAL

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
	JEAN LEE LIVELY		2 Longleaf Dr. GREENWOOD IN 46143	BANKING
Spouse	EARL RALPH RUSK		Longleaf Dr. GREENWOOD IN 46143	CONSTRUCTION MANAGER
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	MITCHELL	900 AVENUE B Boulder City NV 89005	1972	Yes ☑ No ☐
High School	Boulder City	1101 5TH STREET Boulder City, NV 89005	1975-1978	Yes ☑ No ☐
College University	UNLV	4505 S. MARYLAND PKWY LAS VEGAS, NV 89154	1979-1982	Yes ☐ No ☑
Other				Yes ☐ No ☐

Type of degree obtained, if any.....

College or university where obtained.....

Applicant s initial.....

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 or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☑ No ☐

County Clark State NEVADA Date registered 4/1979

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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant s initial .....

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
DEFENDANT	5-14-2009	A-09-590331C	LAS VEGAS, CLARK, NV	DISMISSAL
DEFENDAT	3-14-2002	02A447778	LAS VEGAS CLARK, NV	DISMISSAL
DEFENDANT	3-30-2000	00A416955	LAS VEGAS, CLARK, NV	DISMISSAL

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:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
RL HOMES, LLC	LIMITED LIABILITY COMPANY	7-23-2008
RL HOMES, LLC	LIMITED LIABILITY COMPANY	3-18-2008

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
8/2005 - PRESENT	7 CONOUGH LANE	LAS VEGAS	NV. CLARK
1/1993 - 8/2005	7784 W. ROSADA WAY	LAS VEGAS	NV, CLARK

Applicant s initial _____

8. 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
5/2010 - Present	BETTER BUILDING TECHNOLOGIES 4105. RAMPART BLVD STE 390 LAS VEGAS, NV, 89145	N/A
Title	**Description of Duties**	**Name of Supervisor**
PRINCIPAL	DAILY OPERATIONS, BUSINESS PLANNING CONTRACTS, FINANCING	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
2005-2010	RETIRED	N/A
Title	**Description of Duties**	**Name of Supervisor**
N/A	MANAGED PERSONAL ASSETS	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
2001 - 2005	RL HOME, LLC LAS VEGAS, NV	BUSINESS CLOSED
Title	**Description of Duties**	**Name of Supervisor**
PRINCIPAL	DAILY OPERATIONS, FORWARD PLANNING CONTRACTING, FINANCING	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1996 - 2001	AMERICAN PREMIERE HOMES / DEV. LAS VEGAS, NV	STARTED RL HOMES
Title	**Description of Duties**	**Name of Supervisor**
MANAGING MEMBER	DAILY OPERATION, CONTRACTING, DEVELOPMENT	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1993 - 1996	FALCON HOMES LAS VEGAS, NV	BUSINESS DOWN SIZING
Title	**Description of Duties**	**Name of Supervisor**
VP CONSTRUCTION	MANAGED CONSTRUCTION DEPARTMENT	MARK DOPPEY
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1992 - 1993	DEL WEB LAS VEGAS, NV	OFFERED MANAGEMENT FALCON HOMES
Title	**Description of Duties**	**Name of Supervisor**
CONSTRUCTION SUPERINTENDANT	MANAGED DAILY SITE CONSTRUCTION	DO NOT RECALL
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1989 - 1992	LIVELY CONSTRUCTION / DEV LAS VEGAS, NV	BUSINESS SLOWDOWN
Title	**Description of Duties**	**Name of Supervisor**
OWNER	MANAGED ALL ASPECTS OF GENERAL CONTRACTING	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1984 - 1989	METROPOLITAN HOMES LAS VEGAS, NV	BUSINESS CLOSED IN LAS VEGAS
Title	**Description of Duties**	**Name of Supervisor**
CONSTRUCTION SUPERINTENDENT	MANAGED CONSTRUCTION TRADES, CONTRACTS, HOMEOWNER WARRANTY	DAN MALCOLM

If additional space is needed, continue on page 10 or provide attachment.

Applicant s initial .....

9. 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 PAT BERTHES	Home	W. BEER SPRINGS LAS VEGAS NV 89131	-	20
Employer METRO POLICE	Business	14155 ARVILLE ST. LAS VEGAS, NV 89102		
Name BRUCE BETTRIDGE	Home	7 EVERGREEN OAKS DR. HENDERSON, NV 89052		15
Employer RETIRED	Business	N/A		
Name SALLY GALATI	Home	2 OWLS PEAK COURT LAS VEGAS, NV 89144		8
Employer DRURY GALATI LTD	Business	3615 SOUTH TOWN CENTER DR. Suite 100 LAS VEGAS, NV 89144		
Name PATRICK NUNES	Home	3 19TH STREET Huntington BEACH, CA 92648		20
Employer LDI	Business	1587 E BENTLEY DR. CORONA, CA 92879		
Name DENNIS MORGAN	Home	NightWind LAS VEGAS, NV 89130		25
Employer VALLEY AIR	Business	9225 S. MAN ST. LAS VEGAS, NV 89139		

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. 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

CONTRACTOR, NEVADA, 16 YEARS,

12. Have you ever applied for a city, county of 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.

Applicant's initial .....

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☑ No ☐

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

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

15. 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 ☑

16. 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 ☑

17. 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/or controlled substances? Yes ☐ No ☑

18. 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 close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

Date of photograph 12/15/2018

Applicant s initial

STATE OF Nevada
ss.

COUNTY OF Clark

I, ROBERT L LIVELY JR, 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 case for denial or revocation of a manufacturer 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 of fraudulent, and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 15th day of December 2018

Notary Public

DENISE HARTGROVE
Notary Public - State of Nevada
County of Clark
APPT. NO. 18-4224-1
My App. Expires Oct. 8, 2022

(seal)

Applicant s initial

ADDITIONAL INFORMATION

SECTION 6 (I)

DEFENDANT 11-26-1997 97A381725 LAS VEGAS, NV, Clark Dismissal

DEFENDANT 1999 LAS VEGAS, NV, Clark Dismissal

SECTION 8 Employment

1980-1984 PARSEE CONSTRUCTION LAS VEGAS, NV OFFERED ADVANCEMENT METROPOLITAN DEV ASSISTANT SUPERINTENDANT, WORKED WITH PROJECT SUPERINTENDANT TO MANAGE CONSTRUCTION OF SINGLE AND MULTI FAMILY HOMES.

Applicant s initial

APPLICATION FOR CERTIFICATION AS A PROVIDER OF INTERNET PHARMACY SERVICES

Addendum to Pharmacy Application
(Only required if providing internet services)

GENERAL INFORMATION

Name of Nevada license pharmacy: CMH Pharmacy, LLC

Nevada license number: _____

Websites in use or intended to be used: TBD

Affiliated websites (websites that link to or otherwise direct users to your website):
NONE

VIPPS CERTIFICATION

Is the pharmacy VIPPS (Verified Internet Pharmacy Practice Sites administered be NABP) certified? Please provide a copy with application. Yes ☐ No ☑

If yes, please sign and date page 3 and you will not need to answer questions 1 through 8.

PHARMACIES LACKING VIPPS CERTIFICATION

1. Is the pharmacy licensed in each state in which the pharmacy will practice pharmacy Yes ☐ No ☑

PLEASE ATTACH A SEPARATE SHEET LISTING ALL THE STATES IN WHICH YOU ARE LICENSED, INCLUDING THE DATE OF INITIAL LICENSURE AND THE LICENSE NUMBER.

2. Does the pharmacy maintain and enforce policies and procedures that ensure the following:

A) That the pharmacy will establish the authenticity of each prescription that the pharmacy receives? Yes ☑ No ☐

B) That the pharmacy will not fill any prescription which has been previously filled by another pharmacy? Yes ☑ No ☐

C) That for each pharmacy the pharmacy fills the prescription cannot be filled by another pharmacy? Yes ☑ No ☐

D) That the pharmacy will authenticate the identity of each patient and prescribing practitioner? Yes ☑ No ☐

E) That the prescriptions will be filled in compliance with all applicable federal and state laws? Yes ☑ No ☐

F) That a patient or the caregiver of the patient may make a complaint to the pharmacy regarding a prescription? Yes ☑ No ☐

G) That if a complaint is made, the complaint will be investigated thoroughly and that the results of the investigation will be communicated to the patient or caregiver? Yes ☑ No ☐

H) That if the investigation of a complaint reveals that the operations of the pharmacy resulted in an error in the processing or filling of the prescription, appropriate remedial action was taken by the pharmacy? Yes ☑ No ☐

I) That the pharmacy will communicate to a patient or a prescribing practitioner any delay that might jeopardize or alter the drug therapy of the patient with respect to delivering the prescribed drug or device? Yes ☑ No ☐

J) That the pharmacy will communicate to a patient information regarding recalls of drugs and the appropriate means to dispose of expired, damaged or unusable drugs or devices? Yes ☑ No ☐

3. Does the pharmacy obtain and maintain patient information necessary to facilitate review of drug utilization and counseling of patients pursuant to any applicable statutes? Yes ☑ No ☐

4. Will the pharmacy provide review of drug utilization and counseling of patients pursuant to the applicable statutes in the state in which the patient resides? Yes ☑ No ☐

5. Does the pharmacy maintain controls of its computer system, information concerning patients, and other such confidential information and documents to prevent unauthorized or unlawful access to all such confidential information and documents? Yes ☑ No ☐

6. Does the pharmacy comply with applicable federal and state laws regarding the following:

   A) To the dispensing of prescription drugs? Yes ☑ No ☐

   B) To the record keeping related to the patients served by the pharmacy, the purchase of prescription drugs and the sale and dispensing of prescription drugs? Yes ☑ No ☐

   C) To the sale of over-the-counter products, including any special requirements related to products that have been identified as precursors to the manufacture or compounding of illegal drugs ? Yes ☑ No ☐

7. Does the pharmacy ship prescriptions to a patient using secure and traceable means? Yes ☑ No ☐

8. Does the pharmacy ship prescriptions to a patient using packaging or devices which will ensure that the prescription is maintained within appropriate standards pertaining to temperature, light and humidity as described in the *United States Pharmacopoeia, 25th* edition, 2002, which is hereby adopted by reference? Yes ☑ No ☐

PLEASE ATTACH A COPY OF YOUR POLICIES AND PROCEDURES.

The signature below certifies that the answers provided in this application are true, correct and complete.

Signature of Owner

12/12/2018
Date

Frontier HealthLaw

Representing Practitioners and Entities in Healthcare and Business Law Matters

March 27, 2019

S. Paul Edwards, General Counsel
Brett Kandt, General Counsel
Nevada State Board of Pharmacy
985 Damonte Ranch Parkway #206
Reno, NV 89521

Re: CMH Pharmacy, LLC – Application for Pharmacy License
Analysis of NRS § 639.264 and 42 U.S.C. § 1320a-7b(b)

Dear Mr. Edwards and Mr. Kandt:

As you are aware, this firm represents CMH Pharmacy, LLC, a Nevada limited liability company ("CMH Pharmacy"); Complete Men's Healthcare, LLC, a Nevada limited liability company ("CMH Practice"); and their sole principal and owner, Robert L. Lively, Jr. ("Mr. Lively"). This firm is also working in association with James D. Boyle, Esq. and Audrey P. Damonte, Esq. of the law firm Holley Driggs Walch Fine Puzey Stein & Thompson, on behalf of CHM Pharmacy, CHM Practice, and Mr. Lively.

On behalf of our clients, and in response to your February 12, 2019 request, we submit this legal analysis in response to the Nevada State Board of Pharmacy's (the "Board") concern as to whether or not CMH Pharmacy's proposed business model violates either 42 U.S.C. § 1320a-7b(b) (commonly referred to as the Anti-Kickback Statute ("Federal AKS")) or Nevada Revised Statute ("NRS") § 639.264 ("Nevada AKS"), which sets forth Nevada's prohibitions regarding kickbacks, rebates, and fee-splitting. Please note that we are presenting an analysis of both the Federal AKS and Nevada AKS out of an abundance of caution, even though our position is that the Board does not possess jurisdiction to adjudicate alleged violations of Federal AKS.

PROCEDURAL BACKGROUND

As you will recall, CMH Pharmacy appeared before the Nevada State Board of Pharmacy ("Board") on January 17, 2019 (the "Appearance") in support of its application to obtain a pharmacy license as an Internet Pharmacy pursuant to NRS §§ 639.231 and 639.23288. Mr. Lively appeared before the Board together with CMH Pharmacy's managing pharmacist, Ms. Alysha McMahon ("Ms. McMahon"), and me as CMH Pharmacy's counsel.

Following a brief overview of CMH Pharmacy's proposed business model by Mr. Lively, the Board expressed concern relating to Mr. Lively's common ownership of CMH Pharmacy and CMH Practice, and questioned whether such common ownership poses a risk of violating either (or both) the Federal AKS or Nevada AKS. The Board then decided to stay the application to allow time to review the issue carefully in light of possible similar future applicants, while acknowledging that it was "waiting" for a

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business like CMH Pharmacy to apply for a license. Mr. Kandt informed me that he would contact me regarding the CMH Pharmacy application.

On February 8, 2019, Mr. Kandt requested a legal analysis of the CMH Pharmacy structure and whether it violates the Federal AKS and Nevada AKS.[1] Following this communication, Mr. Edwards, Mr. Kandt, and I had a phone conference on February 12, 2019 to further discuss the Board's underlying concerns. Mr. Kandt and Mr. Edwards reiterated that the Board was concerned about Mr. Lively's common ownership of CMH Pharmacy and CMH Practice, where practitioners will write prescriptions that CMH Pharmacy ***may*** fill.

In response, we have prepared the analysis below as to whether the CMH Pharmacy ownership structure violates either the Federal AKS or the Nevada AKS. For the reasons set forth in this analysis, CMH Pharmacy respectfully contends that its ownership structure does not violate either the Federal AKS or Nevada AKS. Accordingly, we respectfully request that the Board approve CMH Pharmacy's application and issue a pharmacy license pursuant to NRS §§ 639.231 and 639.23288.

BACKGROUND/CMH PHARMACY BUSINESS MODEL

CMH Pharmacy is organized as a Nevada limited liability company, which, upon obtaining its licensure, intends to be domiciled and do business in Nevada and elsewhere as an Internet pharmacy providing medications, up to and including Schedule III controlled substances. Mr. Lively is the sole member and manager of CMH Pharmacy. Ms. McMahon, a Nevada-licensed pharmacist, will be the pharmacist-in-charge as required by NRS § 639.220. CMH Pharmacy will utilize McKesson Enterprise, M-scripts, and Intercon prescription warning label software, all of which are reputable pharmacy systems utilized widely throughout the industry.

CMH Practice is organized as a Nevada limited liability company, doing business in Arizona. Mr. Lively is the sole member and manager of CMH Practice. CMH Practice offers medical services via telehealth platforms to patients ("CMH Patients"), through its network of Arizona-licensed physicians and other licensed practitioners ("CMH Practitioners"). Critically, the CMH Practitioners ***will not*** have any investment or ownership interest in either CMH Practice or CMH Pharmacy, and will instead be employed by or contracted with CMH Practice to provide professional services at fair market value rates.

CMH Practice and CMH Pharmacy are both solely owned by Mr. Lively, who is not himself a physician or other licensed healthcare provider. To this point, there is no provision under existing Nevada law which prohibits common ownership of entities such as CMH Practice and CMH Pharmacy, and certainly Nevada AKS does not prohibit such common ownership. However, we emphasize that CMH Practitioners will treat CMH Patients and prescribe necessary medications, as determined in the CMH Practitioners' sole medical judgment, without any influence or interference by Mr. Lively or any other non-healthcare provider. When a CMH Practitioner prescribes medication to a CMH Patient, the CMH Patient has sole discretion to determine how and where to fill the prescription. While the CMH Patient may specify, through the CMH Practice portal, that the CMH Patient desires to have the prescription filled by CMH

[1] It is our understanding that the Board mistakenly referenced NRS § 639.232 as a potential concern, as evidenced by the email from Mr. Kandt on February 8, 2019. However, again out of an abundance of caution, we provide a brief legal analysis as follows: Mr. Lively is not a practitioner as defined by NRS § 639.0125, and thus he does not meet the limitations of NRS § 639.232. Accordingly, CMH Pharmacy does not violate NRS § 639.232.

Pharmacy, the CMH Patient singularly controls whether CMH Pharmacy or any other pharmacy of the CMH Patient's choice ultimately fills the prescription. If the CMH Patient decides to have CMH Pharmacy fill the prescription, the medication will be delivered conveniently to the CMH Patient's home via direct shipping. CMH Pharmacy will collect the total cost of the transaction, including the retail price of the medication, plus applicable shipping charges and retail taxes for any prescription for which the CMH Patient chooses to have filled by CMH Pharmacy, just as with a transaction handled by any other licensed pharmacy. No part of the transaction costs collected by CMH Pharmacy will be shared with or otherwise paid to CMH Practice or any CMH Practitioners.

Furthermore, no CMH Patient is required to use CMH Pharmacy to fill any prescriptions. To the contrary, CMH Patients may use *any* pharmacy of their choosing to fill a prescription. Likewise, each CMH Patient may designate a choice of pharmacy on the CMH Practice's patient-specific (Web) portal. CMH Patients who use CMH Pharmacy will pay fair market value rates for its product and services, just as they would for any third-party prescription fill and delivery service. We emphasize that both CMH Practice and CMH Pharmacy intend to operate on a cash-only basis. To that extent, neither entity intends at this time to bill or collect payment for services or items from any public or private third-party payors, including, without limitation, Medicare, Medicaid, and TRICARE.

Once operational, CMH Pharmacy will offer low-cost, FDA-approved, and physician-backed products that empower patients to take care of their health from the privacy of their own home. Specifically, CMH Pharmacy, as well as CMH Practice, will focus on addressing an underserved demographic: adult men. Research shows that adult men are less likely than women to seek out healthcare services and are more likely to seek out solutions to their health concerns on the Web, particularly for sensitive matters like erectile dysfunction, sexually transmitted diseases, and hair loss. By expanding access to medical examinations and prescriptions for medications to treat health issues specific to men, CMH Practice offers services to a community that otherwise might not obtain appropriate care. Although CMH Patients will be under no compulsion to fill their prescriptions through CMH Pharmacy, our clients anticipate that many CMH Patients will freely and voluntarily choose to do so given the convenience and privacy that CMH Pharmacy's proposed business model will afford.

Ultimately, CMH Practice and CMH Pharmacy anticipate a relationship that is one of collaborative healthcare providers who are both dedicated to providing high-quality, low-cost products and services to a patient base that prioritizes convenience and privacy. This model is consistent with emerging models within the healthcare industry that emphasize greater collaboration through the use of technological innovation and population health management. Although Mr. Lively owns both CMH Practice and CMH Pharmacy, each entity will operate a separate business, in accordance with all applicable laws, and neither will unduly interfere with the affairs of the other. Importantly, neither business offers, delivers or pays any form of consideration to CMH Practitioners to induce or compensate for the referral of prescriptions to CMH Pharmacy and/or CMH Practice.

LEGAL ANALYSIS

A. Federal Anti-Kickback Statute.

The Federal AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program.[2] For purposes of the Federal AKS, "remuneration" includes the transfer of anything of value,

[2] 42 U.S.C. § 1320a-7b(b).

directly or indirectly, overtly or covertly, in cash or in kind.[3] The Federal AKS has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of items or services or to induce further referrals.[4] The Federal AKS has safe harbor regulations that define practices that are not subject to the Federal AKS because such practices would be unlikely to result in fraud or abuse.[5]

Notably, the Federal AKS is limited in scope to remuneration tied to referrals of items or services reimbursable by a federal healthcare program, such as Medicare or Medicaid. As noted, both CMH Practice and CMH Pharmacy intend to operate on a cash-only basis and therefore will not bill and collect payment from any third-party payors, including any federal healthcare programs. In other words, neither party will make or receive any referrals of items or services reimbursable by a federal healthcare program, and thus the Federal AKS simply does not intersect with either entity's operations.

Nevertheless, we believe that even if the Federal AKS did apply, CMH Pharmacy's proposed business model would not result in a violation of the statute. That is because there will be no "transfer" of any "remuneration" between CMH Practice and CMH Pharmacy, each of which is a separate legal entity with separate operations, including financial, which will not be comingled or otherwise shared with the other entity's. To reach a contrary conclusion, one would have to assume that a remunerative relationship arises from Mr. Lively's common ownership, insofar as he may receive a return on his investment in CMH Pharmacy and reinvest that return into CMH Practice, which, in turn, may remunerate the CMH Practitioners. With respect to both potential sources of remuneration – (1) the return on Mr. Lively's investment in CMH Pharmacy and (2) any compensation paid by CMH Practice to CMH Practitioners that could be linked to funds reinvested by Mr. Lively from any return on his investment in CMH Pharmacy – a safe harbor shields the remuneration.

In regard to the first potential source of remuneration, we believe any return on investment that Mr. Lively receives from his investment interest in CMH Pharmacy complies with the Federal AKS safe harbor for investment interests. This safe harbor provides, in relevant part, "remuneration" for Federal AKS purposes does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor with respect to an entity, as long as the following eight standards are met:

1. No more than 40 percent of the value of the investment interests of each class of investment interests may be held in the previous fiscal year or previous 12 month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.

2. The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.

3. The terms on which an investment interest is offered to an investor who is in a position to

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[3] *See id.*

[4] *See, e.g.*, *United States v. Borrasi*, 639 F.3d 774 (7th Cir. 2011); *United States v. McClatchey*, 217 F.3d 823 (10th Cir. 2000); *United States v. Davis*, 132 F.3d 1092 (5th Cir. 1998); *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir. 1985), *cert. denied*, 474 U.S. 988 (1985).

[5] *See* 42 C.F.R. § 1001.952.

make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.

4. There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

5. The entity or any investor must not market or furnish the entity's items or services (or those of another entity as part of a cross referral agreement) to passive investors differently than to non-investors.

6. No more than 40 percent of the entity's gross revenue related to the furnishing of health care items and services in the previous fiscal year or previous 12-month period may come from referrals or business otherwise generated from investors.

7. The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

8. The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.[6]

In this case, CMH Pharmacy can ensure compliance with the foregoing elements because Mr. Lively is the 100% owner of CMH Pharmacy and, not being a licensed healthcare provider himself, is not "in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for" CMH Pharmacy. The only individuals who could be in such a position are the CMH Practitioners, but as noted, they are not, and will not be, investors in, or hold ownership interests in, CMH Pharmacy or otherwise have any financial relationship with CMH Pharmacy, and as such the hypothetical possibility that such a violation of Federal AKS could occur is simply non-existent.

In regard to the second potential source of remuneration, we believe any compensation to the CMH Practitioners complies with the Federal AKS safe harbors for employees or personal services and management contracts, depending on whether the particular CMH Practitioner is engaged by CMH Practice as either an employee or an independent contractor. As to those CMH Practitioners who are employees of CMH Practice, we can assure that they have a "bona fide employment relationship" with CMH Practice, which is the only requirement for remuneration to an employee who is in a position to make referrals for items or services reimbursable by a federal healthcare program to be excepted under the Federal AKS.[7] As to those CMH Practitioners who are independent contractors of CMH Practice, we can further assure that they all have written agreements which comply with the following elements of the personal services and management contracts safe harbor:

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[6] 42 C.F.R. § 1001.952(a)(2).
[7] 42 C.F.R. § 1001.952(i).

1. The agreement is set out in writing and signed by the parties.

2. The agreement covers all of the services the CMH Practitioner provides to CMH Practice for the term of the agreement and specifies the services to be provided by the PMH Practitioner.

3. If the agreement is intended to provide for the services of the CMH Practitioner on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.

4. The term of the agreement is for not less than one year.

5. The aggregate compensation paid to the CMH Practitioner over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs.

6. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

7. The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.[8]

To this extent, any remuneration to an independent contractor CMH Practitioner who is in a position to make referrals for items or services reimbursable by a federal healthcare program is thus excepted under the Federal AKS.

Finally, even if the potential sources of remuneration described above do not fit precisely within the noted safe harbors, the remuneration still would not violate the Federal AKS because CMH Pharmacy, CMH Practice, and the CMH Practitioners lack the requisite criminal *intent* to induce or reward referrals among themselves. Intent here cannot be surmised solely on the basis of common ownership of CMH Pharmacy and CMH Practice by Mr. Lively. As noted above, moreover, CMH Patients are free to choose any pharmacy to fill a prescription from a CMH Practitioner, and no party, including CMH Pharmacy or Mr. Lively, will obstruct or interfere with that choice. If CMH Patients select CMH Pharmacy to fill a prescription, it will be because they selected CMH voluntarily, not because CMH Pharmacy or Mr. Lively induced or compensated the CMH Practitioner to make a referral to CMH Pharmacy. In short, the factual circumstances of CMH Pharmacy's and CMH Practice's business models are such that one cannot infer the necessary intent under the Federal AKS to trigger a statutory violation.

B. Nevada Anti-Kickback Statute.

Nevada AKS provides as follows:

> No registered pharmacist, or owner of any pharmacy licensed under the provisions of this chapter, may offer, deliver or pay any unearned rebate, refund, commission, preference,

[8] 42 C.F.R. § 1001.952(d).

> patronage dividend, discount or other unearned consideration to any person, whether in the form of money or otherwise, as compensation or inducement to such person for referring prescriptions, patients, clients or customers to such pharmacist or pharmacy, irrespective of any membership, proprietary interest or co-ownership in or with any person by whom such prescriptions, patients, clients or customers are referred.[9]

The statute further states that the "furnishing to a practitioner by a pharmacist or a pharmacy of prescription blanks bearing the name or name and address of any pharmacy is an unearned rebate and an inducement to refer patients to such pharmacist or pharmacy."[10] Unlike the Federal AKS, the Nevada AKS is not limited in scope to kickbacks, rebates, and fee-splitting in connection with only certain government programs. Neither does the Nevada AKS include the safe harbor provisions present in the Federal AKS, nor the high-level mens rea element expressly set forth in the Federal AKS ("knowing and willful"). Rather, it governs a broad spectrum of possible consideration—offered, delivered or paid—which is prohibited as an inducement or compensation for the referral of a prescription, patient, client or customer to a pharmacist or pharmacy. Nevertheless, it is critical to note that the Nevada AKS is: (1) a prohibitory statute which requires an element of intent (*i.e.*, mens rea); and (2) requires an affirmative action on the part of an accused pharmacist or owner of a pharmacy. Neither of these elements exists in this matter.

While the Federal AKS has been interpreted extensively in case law and guidance materials issued by the Office of Inspector General within the U.S. Department of Health and Human Services, the Nevada AKS has not been similarly a subject to any reported case law or guidance materials that we are able to locate. However, several states having similar anti-kickback statutes have guidance materials from which we can draw parallel instruction.

For example, the Supreme Court of Washington has concluded that its anti-kickback statute does not prohibit a patient from paying a health care provider for services rendered or prescriptions received under the auspices that such payment constitutes the receipt of a "profit" by the provider.[11] This is because, as the court observed, a "profit" is not a "kickback", and it defies logic to believe the legislature intended to prohibit a health care provider from making a profit on legitimate transactions (in this case, for the sale of prescription diet drugs from a physician to his patients.[12] A different example under Florida law addressed the issue of whether the Florida state anti-kickback statute was unconstitutional under the doctrine of implied conflict, insofar as the Florida statute excluded the safe harbor provisions of the Federal AKS and set a much lower element of *mens rea* than did the Federal AKS.[13] The court's concern in Florida centered on the points that the Florida statute criminalized actions that were protected under the Federal AKS (pursuant to safe harbor allowances), and further criminalized actions that the Federal AKS did not because of the higher degree of requisite *mens rea*.[14]

Accordingly, while it is not clear how the Board might apply the Nevada AKS in a given set of circumstances where an alleged violation has occurred, we are concerned that the issues such as those addressed by the Supreme Court of Washington and the Florida Court of Appeals are present here—even assuming arguendo that CMS Pharmacy's business model arises to a level that would constitute a

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[9] NRS § 639.264(1).
[10] NRS § 639.264(2).
[11] *Wright v. Jeckle*, 144 P.3d 301, 305 (Wash. 2006) (en banc).
[12] *Id.*, at 306.
[13] *State v. Harden*, 873 So.2d 352, 355 (Fla. Dist. App. 2004).
[14] *Id.*

violation of the Nevada AKS (which it does not). Instead, we are confident that CMH Pharmacy's proposed business model does not violate the Nevada AKS, largely for the reasons already noted in the Federal AKS analysis. CMH Pharmacy and CMH Practice will each separately bill and collect from patients on a cash-pay basis for their respective services, and neither entity will remunerate the other entity or its personnel. Although both entities will share common ownership held by Mr. Lively, neither entity will directly hold an ownership interest in the other, nor will their respective employees or agents, including the CMH Practitioners, hold any such ownership interest. We restate again that all CMH Patients will be free to fill any prescription issued by a CMH Practitioner at any pharmacy of their choice, and CMH Practice will maintain written policies and a clear notice on its Web portal to this effect. For its part, CMH Pharmacy will maintain a written policy not to allow any special discounts to CMH Patients that are not offered to the general public.

Also, CMH Pharmacy will not furnish any practitioner, whether a CMH Practitioner or otherwise, with prescription blanks bearing the name or address of CMH Pharmacy. CMH Pharmacy will have (and will enforce) a written policy prohibiting any furnishing of prescription blanks to any practitioners, whether a CMH Practitioner or otherwise. Likewise, CMH Practice will also have (and will enforce) written policies prohibiting acceptance of prescription blanks from any pharmacy, whether CMH Pharmacy or otherwise.

C. Due Process Concerns.

Lastly, CMH Pharmacy wishes to express its concern that the Board's assessment of CMH Pharmacy's business model as potentially in violation of either Federal AKS or Nevada AKS appears to be an improper infringement of CHM Pharmacy's due process rights.

Most importantly, the Nevada AKS is an intent-based regulatory statute, which in effect requires an affirmative action by an accused to engage in conduct that violates the statute. As noted above, the relevant section of the statute reads:

> No registered pharmacist, or owner of any pharmacy licensed under the provisions of this chapter, may offer, deliver or pay any unearned rebate, refund, commission, preference, patronage dividend, discount or other unearned consideration to any person, whether in the form of money or otherwise, as compensation or inducement to such person for referring prescriptions, patients, clients or customers to such pharmacist or pharmacy, irrespective of any membership, proprietary interest or co-ownership in or with any person by whom such prescriptions, patients, clients or customers are referred.

NRS § 639.264(1). Thus, at a minimum the statute plainly requires at least the following to exist prior to the leveling of an accusation that a pharmacist or owner of a pharmacy has violated the statute: (1) the accused pharmacist must be registered with the Board, or the accused pharmacy licensed by the Board; (2) the accused pharmacist or pharmacy must intentionally "offer, deliver or pay any unearned rebate, refund, commission, preference, patronage dividend, discount or other unearned consideration" to a third person; and (3) said offer, delivery or payment must be intended to compensate or induce the third person to "[refer] prescriptions, patients, clients or customers" to the pharmacist and/or pharmacy. In the instant matter, not one of these mandatory occurrences has transpired.[15]

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[15] Identifying each of these three requirements is in keeping with Nevada's well-stated rule of statutory construction that "Courts must construe statutes and ordinances to give meaning to all of their parts and language, [and] [t]he court should read each sentence, phrase and word to render it meaningful within the

The process by which the Board may adjudicate wrongdoing against a registered pharmacist or licensed pharmacy is situated in both the Nevada Administrative Procedures Act, NRS §§ 233B.121 through 233B.150 (the "NAPA"), as well as within the Board's regulatory provisions (*e.g.*, NAC §§ 639.945 – 639.978). Neither statutory nor regulatory realm provides for the Board to make a conjectural or hypothetical assessment of whether a non-effectuated action might violate the Nevada AKS. That is, insofar as CHM Pharmacy has yet to engage in any action which could fairly be alleged to constitute a violation of the Nevada AKS, due process does not permit the Board to prematurely assign liability (or guilt)[16] for a conjectural violation of the Nevada AKS.[17]

Thus, CMH Pharmacy respectfully suggests that the more prudent approach in this matter is to (1) issue CMH Pharmacy its sought-after license, and (2) examine and police CMH Pharmacy to ensure that it is (and remains) compliant with the business model explained herein and that its business activities do not violate the Nevada AKS. Certainly, CMH Pharmacy is willing and able to work closely with the Board—as a partner that understands its special obligation to the citizens of Nevada to ensure a safe, conscientious and regulatory-compliant business—to address any regulatory concerns that the Board may raise. And, frankly, should the Board ever allege that CHM Pharmacy has acted in a manner prohibited by the Nevada AKS, CHM Pharmacy should face the brunt of the Board's adjudicatory remedies for any such proven accusations (following, of course, a fair due process hearing pursuant to the NAPA).

CONCLUSION

In summary and as shown above, CMH Pharmacy's proposed business model does not violate either the Federal AKS or the Nevada AKS.

CMH Pharmacy understands that the Board has concerns about not only the CMH Pharmacy application before the Board in the instant matter, but also about future applications by other telehealth-related pharmacies. While we cannot provide assurances to the Board regarding future applicants, and we do not believe CMH Pharmacy's application should be judged on the basis of generalized concerns about future applicants, CMH Pharmacy believes that its application meets all applicable requirements under Nevada law and other guiding legal principles. CMH Pharmacy further assures the Board that it intends to fully comply with any and all regulations and laws applicable to CMH Pharmacy as may be promulgated by the Nevada Legislature and as enforced by the Board.

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context of the purpose of the legislation." *Bd. of County Commrs v. CMC of Nevada*, 99 Nev. 739, 744 (Nev. 1983).

[16] CMH Pharmacy notes that NRS § 639.310 states that "unless a greater penalty is specified, any person who violates the provisions of this chapter is guilty of a misdemeanor." This is critical, insofar as exposure to a criminal remedy amplifies the due process protections to which CMH Pharmacy (and potentially Mr. Lively and/or Ms. McMahon) is entitled.

[17] Critically, the Nevada Legislature has not adopted the Nevada AKS as a strict-liability statute. Thus, the Nevada AKS requires that the Board (or a court) determine that an actual violation of the statute has occurred through actions by an accused, not speculate that some type of violation may occur through unproven (or worse, un-effectuated) actions. *See, e.g.*, *Cities Service Co. v. Dep't of Energy*, 520 F.Supp. 1132, 1140-41 (D. Del. 1981) (court will not issue an advisory opinion that an actor did not violate administrative regulations simply because the actor believes an agency might eventually allege such violations). Such is a similar situation herein, where the Board appears to be speculating that CMH Pharmacy may violate the Nevada AKS—essentially, an advisory opinion—when no violating conduct has occurred, no violating conduct has been alleged, and no violating conduct has been adjudicated.

We trust that this analysis alleviates the Board's initial concerns regarding whether common ownership of a medical practice and a pharmacy violates either the Federal AKS or the Nevada AKS. Because there is no legal or regulatory basis for the Board to deny the application of CMH Pharmacy in view of either the Federal AKS or Nevada AKS, we hereby request that the Board grant CMH Pharmacy a Nevada pharmacy license.

Compliance with all Board rules and regulations is of the utmost importance to CMH Pharmacy. Should the Board have any further concerns after review of this requested analysis, CMH Pharmacy is committed to ensure any additional and appropriate safeguards are in place to satisfy the Board. If the Board has any further concerns, please do not hesitate to contact me.

Sincerely,

Ayesha Mehdi, Esq.

cc: James D. Boyle, Esq. (via email only)

HOLLEY DRIGGS
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PLEASE REPLY TO LAS VEGAS OFFICE
WRITER'S EMAIL: JBOYLE@NEVADAFIRM.COM

May 10, 2019

Via Electronic Mail and U.S. Mail

Brett Kandt, Esq.
General Counsel
Nevada State Board of Pharmacy
985 Damonte Ranch Parkway #206
Reno, Nevada 89521

Re: CMH Pharmacy, LLC – Application for Pharmacy License
Responses to Supplemental Questions

Dear Mr. Kandt:

This letter serves to respond to the supplemental questions posed to Applicant CMH Pharmacy, LLC ("CMH Pharmacy") by the Nevada State Board of Pharmacy (the "Board") in your letter dated April 18, 2019. In order of the Board's questions, CMH and Complete Men's Healthcare, LLC, ("CMH Practice") state as follows:

1. As noted in the prior memorandum to the Board dated March 27, 2019, CMH Practice offers medical services via telehealth platforms to patients ("CMH Patients") through its network of Arizona-licensed physicians and other licensed practitioners ("CMH Practitioners"). The CMH Practitioners do not (and will not) have any investment or ownership interest in either CMH Practice or CMH Pharmacy, and will instead be employed by or contracted with CMH Practice to provide professional services at fair market value rates.

   When a CMH Practitioner prescribes medication to a CMH Patient, the CMH Patient has sole discretion to determine how and where to fill the prescription. While the CMH Patient may specify—through the CMH Practice portal—that the CMH Patient desires to have the prescription filled by CMH Pharmacy, the CMH Patient singularly controls whether CMH Pharmacy or any other pharmacy of the CMH Patient's choice ultimately fills the prescription. If the CMH Patient decides to have CMH Pharmacy fill the prescription, the medication will be delivered conveniently to the CMH Patient's home via direct shipping. CMH Pharmacy will collect the total cost of the transaction, including the retail price of the medication, plus applicable shipping charges and retail taxes for any prescription for which the CMH Patient chooses to have filled by CMH Pharmacy, just as with a transaction handled by any other licensed pharmacy.

No part of the transaction costs collected by CMH Pharmacy will be shared with or otherwise paid to CMH Practice or any CMH Practitioners. Moreover, CMH Practitioners do not receive any remuneration or other form of payment or consideration based on the number of prescriptions that CMH Pharmacy fills, and neither do CMH Practitioners receive any form of incentive to write prescriptions for CMH Pharmacy (or any other pharmacy, for that matter).

Instead, CMH Practitioners are either a direct employee of CMH Practice or are engaged as an independent contractor with CMH Practice. CMH Practice's compensation for its direct employees is based on a contract salary; CMH Practice's contract payment rates for independent contractors will be based on the type of consultation the particular CMH Practitioner provides and compliance with applicable state regulatory requirements.

2. With regard to processing prescriptions ordered through CMH Pharmacy, CMH Pharmacy will receive requested fulfillment of prescriptions from CMH Practitioners through the portal operated by CMH Practice. The portal is based on McKesson Corporation's proprietary EnterpriseRx Saas software and its related pharmacy management system. Utilizing the EnterpriseRx Saas software, CMH Pharmacy will manage its relationships with CMH Practitioners and CMH Patients, through which CMH Pharmacy can receive and process prescriptions, manage CMH Patient records and profiles, and monitor and oversee business-wide pharmacy operations. As the Board knows, the EnterpriseRx Saas software and its related pharmacy management system are well-respected in the industry as a leading pharmacy operations management system.

   However, as noted above, CMH Patients are not required to obtain prescriptions through CMH Pharmacy. With regard to prescriptions that a CMH Patient brings or transfers to another pharmacy, CMH Practice and CMH Pharmacy cannot speak to the specific means by which a CMH Patient will deliver such a prescription, but the expectation is that a CMH Patient will do so in the same ordinary courses used by other customers who bring a prescription to a pharmacy of his/her choice. Certainly, CMH Practice expects CMH Practitioners to fully cooperate with any request made by a CMH Patient that a prescription be forwarded or transferred to the pharmacy of the CMH Patient's choice.

3. With regard to the patient questionnaire that CMH Practice will utilize—which is effectively a patient intake document (a "PHR")—in addition to general patient contact and demographic information, CMH Patients will be asked specific questions regarding: the health condition for which the CMH Patient is seeking treatment (including symptoms, effects, medical concerns/questions and background information); related questions associated with any other underlying medical causes or symptoms; previous or current additional medical history(ies) (including pharmaceuticals that the CMH Patient is or has recently been prescribed); prior conditions and surgeries; known allergies or negative reactions to prior medical treatments or pharmaceuticals; family medical history; identification of General Practitioner; and date of last physical exam. CMH Practice will work closely with CMH Practitioners in developing and evolving the PHR to meet the needs of CMH Patients. All data obtained by CMH Practice via the PHR will be obtained, maintained and transmitted in compliance with applicable state and federal regulations. The PHR will be electronically forwarded to or made

available to, and reviewed by, the appropriate CMH Practitioner prior to treatment of a CMH Patient.

With regard to the statutory and regulatory provisions identified in the Board's letter, in addition to CMH Practice's and CMH Pharmacy's representation that it will undertake all good faith efforts to ensure compliance with all applicable statutory and regulatory requirements, CMH Practice and CMH Pharmacy state:

a. NRS 639.235 establishes requirements for the writing or prescribing of a prescription, and in particular identifies limitations and requirements which must be followed when the writing or prescribing of a prescription by a person who is not licensed in Nevada, but who is authorized by the laws of another state to write or prescribe a prescription. Furthermore, subsection (4) of the statute states that "a bona fide relationship between the patient and the person prescribing the controlled substance shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics, including, without limitation, through telehealth, within or outside this State or the United States by the person prescribing the controlled substances within the 6 months immediately preceding the date the prescription was issued."

   CMH Practice's and CMH Pharmacy's business model is designed to ensure compliance with the statutory requirements of NRS 639.235. To this point, it is also critical to note that the business model is designed to be effectively a "closed-universe" system with regard to the relationship between CMH Patients and CMH Practitioners; that is, the business model is designed to ensure that the CMH Patient is being serviced by a CMH Practitioner within the CMH Practice network. As such, CMH Practice and CMH Pharmacy are strongly confident that their business model will ensure compliance with subsection (4) of the statute. CMH Pharmacy does not intend to fill or dispense a prescription that is transmitted or delivered by a practitioner outside of the CMH Practitioners network.

b. NRS 639.2391 specifically addresses the prescribing of controlled substances for the treatment of pain, describing in general terms the prescribing of controlled substances identified in Schedules II, III or IV, and also addressing the prescribing of "opioids." To this point, CMH Pharmacy will not be dispensing or filling prescriptions for controlled substances identified under NAC 453.520 (Schedule II) or NAC 453.540 (Schedule IV). Neither will CMH Pharmacy engage in the dispensing nor filling of prescriptions for "opioids" as this term is generally defined by the Nevada Division of Public and Behavioral Health.

   With regard to controlled substances identified under NAC 453.530 (Schedule III), CMH Pharmacy may dispense or fill certain prescriptions for pharmaceuticals identified as Schedule III controlled substances (at this time, CMH Pharmacy only anticipates that it will dispense Testosterone). In such instances, CMH Pharmacy's business model is designed to ensure that CMH Pharmacy is fully compliant with the requirements of NRS 639.2391—including in particular the assurance that a bona fide therapeutic relationship exists between a CMH Patient and a CMH Practitioner

as discussed herein, and as managed through the EnterpriseRx Saas software and its related pharmacy management system deployed by CMH Practice and CMH Pharmacy.

c. NAC 639.752 addresses the requirements a pharmacist must follow when filling or dispensing certain prescriptions. Specifically, the regulation places restrictions on the filling or dispensing of a prescription under identified circumstances, and for such circumstances it identifies required procedures a pharmacist must follow when filling or dispensing a restricted prescription. CMH Pharmacy and its staff pharmacist are fully versed in these requirements, and CMH Pharmacy's business model is designed to ensure compliance with same.

Moreover, subsection (4) of the regulation states that a "bona fide relationship between the patient and the prescribing practitioner shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics within or outside this State or the United States by the practitioner within the 6 months immediately preceding the date the prescription was issued." Here again, CMH Practice's and CMH Pharmacy's business model is designed to ensure compliance with this regulatory requirement. To this point, it is also critical to note that the business model is designed to be effectively a "closed-universe" system with regard to the relationship between CMH Patients and CMH Practitioners; that is, the business model is designed to ensure that the CMH Patient is being serviced by a CMH Practitioner within the CMH Practice network. As such, CMH Practice and CMH Pharmacy are strongly confident that their business model will ensure compliance with subsection (4) of the regulation. CMH Pharmacy does not intend to fill or dispense a prescription that is transmitted or delivered by a practitioner outside of the CMH Practitioners network.

d. NAC 639.945(1)(o) states that the "[p]rescribing [of] a drug as prescribing practitioner to a patient with whom the prescribing practitioner does not have a bona fide therapeutic relationship" by a "holder of any license, certificate or registration issued by the Board or any employee of any business holding such license, certificate or registration" is declared to be "unprofessional conduct and conduct contrary to the public interest."

CMH Practice and CMH Pharmacy understand the clause "bona fide therapeutic relationship" to mean the existence of a "bona fide relationship between the patient and the prescribing practitioner" as defined by NAC 639.752, and the similar provision defined in NRS 639.235. As set forth above, CMH Practice and CMH Pharmacy are confident that their business model is designed to ensure compliance with the regulatory and statutory requirements for ensuring that a "bona fide relationship" exists between a CMH Patient and a CMH Practitioner. This business model is based upon the portal operated by CMH Practice and the EnterpriseRx Saas software and its related pharmacy management system described above. Utilizing the EnterpriseRx Saas software, CMH Pharmacy will manage its relationships with CMH Practitioners and CMH Patients, through which CMH Pharmacy can receive and process prescriptions, manage CMH Patient records and profiles, and monitor and

oversee business-wide pharmacy operations. In addition, CMH Practice can ensure that each CMH Patient is properly examined by a CMH Practitioner within the requisite timeframes required by Nevada law. To this point, it is also critical to note that the business model is designed to be effectively a "closed-universe" system with regard to the relationship between CMH Patients and CMH Practitioners; that is, the business model is designed to ensure that the CMH Patient is being serviced by a CMH Practitioner within the CMH Practice network, such that CMH Practice is fully informed of the examination relationship between a CMH Patient and a CMH Practitioner.

4. When a CMH Patient resides in Nevada, CMH Practitioners will be engaged in full compliance with the licensing requirements administered by the Nevada State Board of Medical Examiners (the "BME") as well as the statutory and regulatory authority administered by other Nevada agencies. For example, CMH Practice will ensure that a physician who is not licensed in Nevada, but who may examine and service a Nevada-resident CMH Patient, obtains a special purpose license pursuant to NRS 630.261(e).

   To this issue, however, CMH Practice notes that BME has jurisdiction over licensing issues with regard to the physicians and other practitioners within the CMH Practitioners network who may examine and serve Nevada-resident CMH Patients. CMH Practice will certainly undertake all good-faith efforts to ensure that it is fully compliant with the regulations and statutes for which BME has regulatory oversight. However, the Board lacks jurisdiction over the regulations and statutes for which BME has regulatory oversight, and the Board should not interject its opinion on the regulations and statutes for which BME has regulatory oversight into the Board's decision with regard to issuance of the license sought by CMH Pharmacy.

5. CMH Practice anticipates that its use of non-practitioners will be limited to ministerial tasks only, for example in the capacity of concierge and customer-service agents. Where such human-to-human contact is necessary, the non-practitioner's role (once trained) will be limited to answering general business, billing/financial, and portal management questions, with all medical and pharmaceutical-related questions referred to a CMH Practitioner.

   However, the business model that CMH Practice will deploy is highly automated through the portal, such that when a CMH Patient directs information and profile data through the portal the CMH Patient is immediately directed to a CMH Practitioner for examination and service. Thus, in the vast majority of instances a non-practitioner is not utilized in the formation of a "bona fide therapeutic relationship" between a CMH Patient and a CMH Practitioner. Rather, the CMH Patient has direct contact with a CMH Practitioner from the outset, and, as discussed above, the "bona fide therapeutic relationship" exits under the business model in compliance with governing statutes and regulations.

CMH Practice and CMH Pharmacy have provided this supplemental information to the Board in good faith and with a design to engage the Board in constructive dialogue with regard to CMH Pharmacy's application to obtain a pharmacy license as an Internet Pharmacy pursuant to NRS §§ 639.231 and 639.23288. Should the Board have any additional questions, CMH Practice and CMH Pharmacy are

prepared to address same before the Board a renewal of the hearing on CMH Pharmacy's application, which we respectfully request occur at the Board's next-scheduled meeting of June 5/6, 2019.

CMH Practice and CMH Pharmacy hereby reserve all rights.

Best regards,

HOLLEY DRIGGS WALCH
FINE PUZEY STEIN & THOMPSON

James D. Boyle

cc: Ayesha Mehdi, Esq. (via electronic mail only)

8B

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ☐Ownership Change (Provide current license number if making changes: PH____
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: EastSide Pharmacy LLC

Physical Address: 5835 S Eastern Ave STE 100

City: Las Vegas State: NV Zip Code: 89119

Telephone: 844-334-1010 Fax: 833-861-0249

Toll Free Number: 844-334-1010 E-mail: ryan@EASTSIDERXLV.COM

Website: N/A

Managing Pharmacist: Jeffery Lang License Number: 17503

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☒	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☐	☒ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☐	☒ Sterile Compounding
		☒	☐ Non Sterile Compounding
All boxes must be checked		☐	☒ Mail Service Sterile Compounding
For the application to be complete		☐	☒ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Ryan L Ross

Original Signature of Person Authorized to Submit Application, no copies or stamps

Ryan L Ross — Print Name of Authorized Person

12/11/18 — Date

Board Use Only	Date Processed: _____	Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Mailing Address: 5835 S Eastern Ave STE 100

City: Las Vegas State: NV Zip: 89119

Telephone: 844-334-1010 Fax: 833-861-0249

Contact Person: Ryan L Ross

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) Ryan L Ross (Name) 5835 S Eastern Ave Ste 100 (Business Address)

b) _____ (Name) _____ (Business Address)

c) _____ (Name) _____ (Business Address)

d) _____ (Name) _____ (Business Address)

2) Provide the number of shares issued by the ~~corporation~~ LLC. 100%

3) What was the price paid per share? N/A

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: _____

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, Ryan L Ross

Responsible Person of Eastside Pharmacy LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Ryan L Ross

Original Signature of Person Authorized to Submit Application, no copies or stamps

Ryan L Ross

Print Name of Authorized Person

12/11/18

Date

Managing Pharmacist

Pharmacist Name: Jeffrey S Long License #: 17503

Pharmacy Name: Eastside Rx

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☑
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☑
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☑
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☑

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Signature _____ Date 12/10/18

Eastside Pharmacy List of Managing Members

Ryan Ross Managing Member 100%.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date.....

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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.....
Nature of License

.....
Name and Address of Establishment for Which License Is Requested

.....
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Ross	Ryan	Lee
Last Name	First Name	Middle Name

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

5 Miracle Ave	Henderson	NV 89002
Present Residence Address-Street or RFD	City	State/Zip

2560 Sunset rd	Dates	Las Vegas	NV 89120
Present Business Address		City	State/Zip

Pharmacy Technician	Dates Jul 2018 - present	Phone: Residence ·
Occupation		Business 702-531-8331

Springfield, OR Lane County	
Date of Birth	Place of Birth (City, County, State)

40		M
Age	Social Security Number	Sex

Green	Blond	Light	170	med	71"
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

Scars, tattoos or distinguishing marks and/or characteristics Tattoo - right shoulder, left arm

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 RLR

MARITAL INFORMATION-Continued

A. **Current Marriage** 3/17/07 (Date) Santa Rita, Gu (City, County)

Spouse's full name (Maiden) Ayleen Martinez S.S. No

Date of Birth Place of Birth Bronx, NY

Resident address Calle Adolfo Sanchez (Street) Las Piedras (City) PR (State) 00771 (Zip)

Telephone: Residence Business N/A

Spouse's employer N/A Occupation Homemaker

Address of employer N/A (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
Merlina Westerman	12/05	12/99	Dissolution	San Diego, CA

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

Name	Street	City	State	Zip	Telephone
Merlina Westerman	3 Clements Way	Murrieta	CA	92563	

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Rosalina Hammack		Lemoore, CA	Spiracle Ave Henderson, NV 89002
Marianne Ross		Portland, OR	Clements Way Murrieta, CA 92563
Gabriella Ross			Calle Adolfo Sanchez Las Piedras, PR 00771

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

FAMILY INFORMATION-Continued

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

Name California Department of Child Support Services

Address P.O. Box 419064 Rancho Cordova, CA 95741

Contact person Clerk of the Court

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Delbert Ross		unknown	
Mother	Kathleen Shrauger		25th M St NW Armegard, ND 58835	clerk
Father-in-Law	Raymond Martinez		Las Piedras, PR	Retired
Mother-in-Law	Maria Diaz		Las Piedras, PR	Retired

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
	Eric Ross		NE Hickory st Vancouver, WA 98682	construc
Spouse	Janice Thorkildson			
	Clifford Ross		Watford city, ND	Clerk
Spouse				
	Cynthia Ross		Glendale, AZ	Nurse
Spouse	Kenneth Damé			
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Rangely Elementary	Rangely, CO	8/83 - 6/88	Yes ☒ No ☐
High School	Rangely High	Rangely, CO	8/91 - 5/94	Yes ☐ No ☒
College University	Grantham University	Lenexa, KS	8/12 - 4/15	Yes ☒ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any BS Business management

College or university where obtained Grantham university

Applicant's initial RR

5 MILITARY INFORMATION:

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

Branch Navy Date of entry-active service 7/31/95

Date of separation 4/21/11 Type of discharge Honorable

Rating at separation MA2 Serial number

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☒ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☒ No ☐

County Clark State WA Date registered 6/18/94

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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☒ No ☒ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial RH

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. 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:

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
9/18 - Present	Stiracle Ave	Henderson, NV	89002
6/18 - 9/18	163 Afternoon Rain Ave	Henderson, NV	89002
7/16 - 6/18	2901 SE 32th St	Gresham, OR	97080
3/13 - 7/16	11645 SE Fuller rd	Portland, OR	97222
3/12 - 3/13	8640 SE Causey Ave APT 1C303	Happy Valley, OR	97086
2/11 - 3/12	15258 SW Milliken Way APT 616	Beaverton, OR	97006
~~7/07 - 2/11~~	~~U.S. Navy~~		
6/08 - 2/11	8760 Redwood Dr unit 144	Santee, CA	92071
5/05 - 6/08	2229A McMillen Dr	Santa Rita, GU	96915
4/02 - 5/05	San Diego, CA		
2/98 - 4/02	Manama, Bahrain		

Applicant's initial DLR

8. 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
7/18 - Present	Sunrise Pharmacy 2500 E Sunset rd Las Vegas, NV 89120	
Title	Description of Duties	Name of Supervisor
Pharmacy Technician	Compounding Lab Manager	Tamara Angeles
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving moved to vegas
6/12 - 7/18	Professional Center 205 Pharmacy 10000 SE Main st Portland, OR 97216	
Title	Description of Duties	Name of Supervisor
Pharmacy Technician	Compounding Lab manager	Krissy Bray
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/12 - 6/12	Fred Meyer Pharmacy Portland, OR	Better position
Title	Description of Duties	Name of Supervisor
Pharmacy Tech	fill prescriptions	Joe
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
7/97 - 3/11	U.S Navy	Tenure
Title	Description of Duties	Name of Supervisor
MA^{2}	Police officer	Jake Englander
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
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, continue on page 10 or provide attachment.

Applicant's initial ....

9. 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 Josh Dilinger	Home	NW 291st St	Ridgefield	WA	98642	9 years
Employer	Business					
Name Kristy Tela	Home	SW 5th St	Gresham	OR	97030	8 Years
Employer Prestige Pharmacy	Business	Portland, OR 97220				
Name Rose Chen	Home	SE 89th Ave	Portland	OR	97266	6 Years
Employer Prestige Pharmacy	Business	Portland, OR 97220				
Name Kamren Northrop	Home	Spirada Ave	Henderson	NV	89002	6 Years
Employer JSMA	Business	Las Vegas, NV				
Name Merlina Westerman	Home	3 Clements Way	Murrieta	CA	92563	21 Years
Employer	Business					

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. 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

12. Have you ever applied for a city, county of 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.

Applicant's initial _____

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

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

15. 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 ☒

16. 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 ☒

17. 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/or controlled substances? Yes ☐ No ☒

18. 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 close of a manufacturer Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒

Date of photograph 12/11/18

Applicant's initial

STATE OF Nevada ss.

COUNTY OF Clark

I, Ryan L Ross, 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 case for denial or revocation of a manufacturer 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Ryan L Ross
Original Signature of Applicant

Subscribed and Sworn to before me this 12th day of December, 2018

Sherry Ross
Notary Public

SHERRY ROSS
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 07-20-2022
Certificate No: 18-3612-1

(seal)

Applicant's initial RLR

ADDITIONAL INFORMATION

Applicant's initial RJR

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date.....

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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 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.....
Nature of License

.....
Name and Address of Establishment for Which License Is Requested

.....
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Lang | Jeffrey | Scott
Last Name | First Name | Middle Name

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

Villa De Conde Way | Las Vegas | NV | 89102
Present Residence Address-Street or RFD | City | State/Zip

5835 S. Eastern Ave | Dates | Las Vegas | NV | 89119
Present Business Address | City | State/Zip

Pharmacist | Dates 5/08 - Present | Phone: Residence .....
Occupation | Business 702 791 3500

Greensburg PA Westmoreland County | M
Date of Birth | Place of Birth (City, County, State) | Sex

Age | Social Security Number

Brown	Black	Light	190	Medium	6'0"
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

Scars, tattoos or distinguishing marks and/or characteristics None Right elbow scar

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.....

MARITAL INFORMATION-Continued

A. **Current Marriage** 7/15/13 (Date) Las Vegas, Clark County, NV (City, County and State)

Spouse's full name (Maiden) Holly C Andrews S.S. No

Date of Birth Place of Birth Panorama, CA

Resident address Villa De Corde Way (Street) Las Vegas (City) NV (State) 89102 (Zip)

Telephone: Residence Business 877 880 0880

Spouse's employer MGM Grand Occupation Beverage Dept.

Address of employer 3799 S. Las Vegas Blvd (Street) Las Vegas (City) NV (State) 89109 (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
Jennifer Lang	1/15/10	4/1/04	Divorce	Newton, NC

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

Name	Street	City	State	Zip	Telephone
Jennifer Lang		Newton	NC	28613	

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Sophie Lang		Las Vegas, NV	Newton, NC
Jefferson Lang		Rogers, AR	Las Vegas, NV
Ruby Lang		Rogers, AR	Las Vegas, NV
Hayes Lang		Las Vegas, NV	Las Vegas, NV
Avery Lang		Las Vegas, NV	Las Vegas, NV

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

FAMILY INFORMATION-Continued

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

Name Benton County Arkansas Family Court

Address 102 NE A St #203 Bentonville, AR 72712

Contact person Clerk of the Court

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	~~Jame~~ Ray Lang	Unknown	Last known Greensboro PA	Unknown
Mother	Marie Taylor	"	Bon Villa Way Tega Cay, SC 29708	Retired
Father-in-Law	James Taylor	"	Bon Villa Way Tega Cay, SC 29708	Retired
Mother-in-Law				

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	Ryan Taylor	"	Atlanta, GA	Engineer
Spouse	Dawn Lang	"	Charlotte, NY	Engineer
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School				Yes ☐ No ☐
High School	Orange County	Orange, VA	8/88 - 6/92	Yes ☑ No ☐
College University	North Carolina @ Charlotte			Yes ☑ No ☐
Other	University of Southern Nevada			Yes ☐ No ☑

Type of degree obtained, if any BS Biochemistry Pharm D

College or university where obtained UNCC USN

Applicant's initial

5 MILITARY INFORMATION:

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

Branch USAF Date of entry-active service 7/92-6/96

Date of separation USAF Type of discharge Honorable

Rating at separation E4 Serial number .....

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☑ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☑ No ☐

County Orange State VA Date registered 6/92

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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial .....

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. 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:

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
12/17-Current	Villa De Cabo Bay	Las Vegas	NV
6/14-12/17	3 Duncan Lane	Bella Vista	AR
6/12-6/14	4 Alaba Circle	Bella Vista	AR
1/10-6/11	6 Eugene Lane	Bella Vista	AR
5/8-1/10	5 Pittman Lane	Bella Vista	AR
2/04-5/08	3472 Modena Circle	Las Vegas	NV
8/01-2/02	Edgefield Dr	North Augusta	SC
5/01-8/01	Atlanta, GA	Atlanta	GA
9/96-5/01	[illegible]	Charlotte	NC
3/94-9/96		Wichita	KS
8/92-3/94	Monterey, CA	Monterey	CA

Applicant's initial _____

8. 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.

12/17 Partell

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
12/17	Partell Pharmacy 5835 S. Easton Ave Las Vegas, NV 89119	
Title	**Description of Duties**	**Name of Supervisor**
PIC	Managing the pharmacy	Robert Seik
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1/16-12/17	837 Henri De Tonti Blvd Springdale, AR 72762	Moved to Las Vegas
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Overnight Pharmacy	Josh Bonetti
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
10/16-10/17	CVS 2001 S Thompson St Springdale, AR 72764	No longer needed 2nd job
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Overnight & Staff Pharmacist	Robin Greer
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
5/05-10/16	Walgreens 4206 W New Hope Road Rogers AR 72758	Left for CVS
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Staff & Overnight Pharmacist	Ryan Walker
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
~~UCB Chemicals~~ 5/01-2/02	N. Augusta, SC UCB Chemicals	Company Shut Down
Title	**Description of Duties**	**Name of Supervisor**
Chemist	Packing Amino Acid Chan Drugs	Najib
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
9/96-5/00	Circle K Charlotte, NC	Graduated College
Title	**Description of Duties**	**Name of Supervisor**
Gas Station Attendant	Cashier	Jeff Bosko
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
8/96-5/00	Clear Creek Animal Hospital Charlotte, NC	Graduated College
Title	**Description of Duties**	**Name of Supervisor**
Vet Tech	Animal surgeries, care, etc	Dr. Steib
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
8/92-7/96	USAF Texas, California, Kansas	4 years ended
Title	**Description of Duties**	**Name of Supervisor**
Senior Airman		

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initials: .....

9. 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 Karen Wallace	Home	Cane	MO	65856		5
Employer Frontier Pharmacy	Business	Springdale	AR	72762		
Name Mary Barbosa	Home	Las Vegas	NV			7
Employer VS Pharmacy	Business	Las Vegas	NV			
Name Tina [illegible]	Home	Las Vegas	NV			10
Employer MGM	Business	Las Vegas	NV			
Name George Andrews	Home	Boulder City	NV			10
Employer MGM	Business	Las Vegas	NV			
Name Am Sparacio	Home	Las Vegas	NV			8
Employer MGM	Business	Las Vegas				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. 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 Las Vegas, Gaming license, 6 years

12. Have you ever applied for a city, county of 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.

Applicant's initial [illegible]

any reason whatsoever? Yes ☐ No ☑

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

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

15. 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 ☑

16. 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 ☑

17. 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/or controlled substances? Yes ☐ No ☑

18. 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 close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

Date of photograph 12/11/15

Applicant's initial

STATE OF Nevada
ss.
COUNTY OF Clark

I, Jeffrey S Lang, 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 case for denial or revocation of a manufacturer 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 12th day of December, 2018

Notary Public

SHERRY ROSS
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 07-20-2022
Certificate No: 18-3612-1

(seal)

Applicant's initial

ADDITIONAL INFORMATION

Applicant's initial 

8C

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206– Reno, NV 89521 – (775) 850-1440

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH_____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☒ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: FALCON PHARMACY

Physical Address: 4500 MEADOWS LANE

City: LAS VEGAS State: Zip Code: NV 89107 Telephone: 702-258-8100 Fax: 7022584244 Toll Free Number: _____

E-mail: falcon.pharmacy1@yahoo.com

Website: _____

Managing Pharmacist: LAILA TAFRESHI License Number: 16858

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds_____)	☐	☒ Parenteral
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☐	☒ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☐	☒ Sterile Compounding
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☐	☒ Mail Service Sterile Compounding
	For the application to be complete	☐	☒ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Leila Tafreshi

Print Name of Authorized Person

09-3-2019

Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: _____

Mailing Address: 4500 MEADOWS LANE

City: LAS VEGAS State: NV Zip: 89107

Telephone: 702-258-8100 Fax: 702 258-4244

Contact Person: LEILA TAFRESHI

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) LEILA TAFRESHI, 4500 MEADOWS LN LAS VEGAS NV 89107
Name Business Address

b) _____
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

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

3) What was the price paid per share? _____

List any physician shareholders and percentage of ownership.

Name: N/A %: N/A

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6 pm Saturday Closed am Closed pm

Sunday Closed am Closed pm 24 Hours NO

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20193308771

APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: LEILA TAFRESHI

Business Name: FALCON PHARMACY

Current Business Address: 4500 MEADOWS LN

City: LAS VEGAS State: NV Zip Code: 89107

Telephone: 702 258 8100 Fax: 702 258 4244

List any physician shareholders and percentage of ownership.

Name: N/A %:

Name: %:

Name: %: N/A

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6 pm Saturday Closed am Closed pm

Sunday Closed am Closed pm 24 Hours NO

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20191330871

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, LEILA TAFRESHI

Responsible Person of FALCON PHARMACY

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Leila TAFRESHI

Print Name of Authorized Person

05-3-19

Date

Managing Pharmacist

Pharmacist Name: LEILA TAFRESHI License #: 16858

Pharmacy Name: FALCON PHARMACY

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☒
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☒
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Signature _____ Date 5-3-2019

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date May-2-2014

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 Retail
Nature of License

Falcon pharmacy 4500 Meadows lane las vegas NV 89107
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
TaFreshi	Leila	—

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

Present Residence Address-Street or RFD	City	State/Zip
diveridge DR	Las vegas	NV 89135

Present Business Address	Dates	City	State/Zip
4500 Meadows lane		Las vegas	NV 89107

Occupation	Dates	Phone: Residence
pharmacist		

Business 702-258-8100

Date of Birth	Place of Birth (City, County, State)
	Iran/Shiraz

Age	Social Security Number	Sex
48		Female

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Hazel	Blond	olive	135lbs	Small	5'3"

Scars, tattoos or distinguishing marks and/or characteristics

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 LT

A. **Current Marriage** Feb-27-1993 (Date) current (City, County and State)

Spouse s full name (Maiden) Mehrdad TaFreshi S.S. No

Date of Birth Place of Birth Iran/Shiraz

Resident address 5 Oliveridge Ct (Street) Las Vegas (City) NV (State) 89135 (Zip)

Telephone: Residence N/A Business 702-258-8100

Spouse s employer Meadows Medical Group Occupation Physician (M.D)

Address of employer 4500 Meadows Lane (Street) Las Vegas (City) NV (State) 89107 (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
N/A				

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

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Keanush TaFreshi		Las Vegas	
Keenia TaFreshi		Las Vegas	

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 LT

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

Name .....

Address .....

Contact person .....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	deceased			
Mother	deceased			
Father-in-Law	deceased.			
Mother-in-Law	Fakhrazam Mansouri		ramada inn Carlsbad, CA 92009	retir

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
	Mehdi Attaran		palm tree lane Murrieta, CA 92563	Sales Manager
Spouse	ojeta Attaran		palm tree lane Murrieta, CA, 92563	engineer real state agent
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Parand middle school	Iran/Shiraz	1982-1984	Yes ☒ No ☐
High School	Bahonar highschool	Iran/Shiraz	1985-1989	Yes ☒ No ☐
College University	UNLV	Las vegas, NV	1994-1996	Yes ☒ No ☐
Other	University of Southern NV	Las Vegas, NV	Aug/2002-6/2007	Yes ☐ No ☐

Type of degree obtained, if any Pharm D

College or university where obtained university of Southern Nevada

Applicant s initial LT

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 or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant s initial LT

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. 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:

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
02-93-Aug-96	8216 Bermuda Beach Dr	Las vegas	NV 89128
09-96 - 09-2006	1729 Corta Bella Dr	las vegas	NV 89134
09-2006- Aug-2015	9521 verlaine ct	Las vegas	NV 89145
Aug 2015 - Sep 2017	olive ridge Dr	las vegas	NV 89135

Applicant s initial LT

6. 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
Feb-1990	Burger King (don't remember)	just experience & found better job
Title	**Description of Duties**	**Name of Supervisor**
Customer Service	Fast food employ	N/A.
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
90-93	Dryclean family owned	Full time student & married (to move to
Title	**Description of Duties**	**Name of Supervisor**
customer Service,	helpers, Customer to bags(?) & pick up order	Ahmad Konndyan(?)
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
97-98	home health Company	full time mom.
Title	**Description of Duties**	**Name of Supervisor**
helping the owner with home health Services medical reason		pharmacy School Farza
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Sep 2006 till current	CVS pharmacy	still working
Title	**Description of Duties**	**Name of Supervisor**
Staff pharmacist	pharmacist Duties/Fill RX/verify RX-type RX, DUR, Insurance processing	Matt Forster,
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**
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, continue on page 10 or provide attachment.

Applicant s initial LS

9. 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 Michael Sax DDS Home	A children's Dentist	8710 West charleston #100	Las vegas			89117
Employer Children's dentist Business	; chandler spring Ave	las vegas	NV	89148.		
Name Farzin Farhangfar MD Home	1 glenview Dr	Las vegas	NV	89134	/ Mountain view rehabilitation hospital	
Employer Farzin Farhangfar MCPC Business	physical Medicine	1 glenview Dr	LV	NV 89134		
Name Magid Bady MD Home	Winchester Dr	LV	NV	89134		
Employer Veinclinic of lv Business	9000 W post Road Suite 200			89145		
Name Reza Moftakari Home	olive ridge Dr	Las vegas,	NV	89135		
Employer Avencia Medical group Business	3150 N tenaya way Suite 240	LV	NV	89135		
Name Ekman Kavrami Home	early Dawn ct	Las vegas	NV	89128		
Employer Anyja Construction Business	2308 Angelfire Street	Las vegas,	NV	89128		

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person s depository? Yes ☒ No ☐
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users
399 personal Box	~~Wells Fargo~~ Bank charlston/215	Las vegas/NV 11730 west charlston Blv	leila Tafreshi, Mehrdad Tafresh Lv NV 89135

11. 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

12. Have you ever applied for a city, county of 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.

Applicant s initial CT

any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

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

15. 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 ☒

16. 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 ☒

17. 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/or controlled substances? Yes ☐ No ☒

18. 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 close of a manufacturer Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒

Date of photograph 05-3-2019

Applicant s initial LT

STATE OF ..... ss.

COUNTY OF clark

I, Leila TaFreshi, 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 case for denial or revocation of a manufacturer 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 of fraudulent, and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 3 day of May, 2019 by Leila TaFreshi

Notary Public

MICHAEL TURNER
Notary Public - State of Nevada
County of Clark
APPT. NO. 12-8075-1
My App. Expires Oct. 12, 2020

(seal)

Applicant s initial

ADDITIONAL INFORMATION

Applicant s initial .....

8D

4/8

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ■ Ownership Change (Provide current license number if making changes: PH 00567

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
■ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: KMART PHARMACY #3592

Physical Address: 5051 E BONANZA RD

City: LAS VEGAS State: NV Zip Code: 89110-3514

Telephone: 702-459-1003 Fax: 847-396-2647

Toll Free Number: 800-416-7565 E-mail: NANCY.THOMAS@SEARSHC.COM

Website: kmart.com

Managing Pharmacist: LYNNA HA License Number: 16983

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☑	☐ Retail	☐	☐ Off-site Cognitive Services
☐	☐ Hospital (# beds ____)	☐	☐ Parenteral
☐	☐ Internet	☐	☐ Parenteral (outpatient)
☐	☐ Nuclear	☐	☐ Outpatient/Discharge
☐	☐ Ambulatory Surgery Center	☐	☐ Mail Service
☐	☐ Community	☐	☐ Long Term Care
☐	☐ Other: _____	☐	☐ Sterile Compounding
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☐ Mail Service Sterile Compounding
	For the application to be complete	☐	☐ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

JENNIFER SPEARES LEHMAN
Print Name of Authorized Person

03/26/2019
Date

Board Use Only	Date Processed: _____	Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DELAWARE

Parent Company if any: TRANSFORM HOLDCO LLC

Mailing Address: 3333 BEVERLY RD BC 260 A

City: HOFFMAN ESTATES State: IL Zip: 60179-0001

Telephone: 847-286-4089 Fax: 847-747-1553

Contact Person: NANCY THOMAS

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) See attached list
Name Business Address

b) _____
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. 1

3) What was the price paid per share? $1

List any physician shareholders and percentage of ownership.

Name: NONE %: 0

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 8 pm Saturday 9 am 5 pm

Sunday 11 am 3 pm 24 Hours NO

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

Kmart Pharmacy
Ownership Information and Officer List

Name	Title	Work address	Ownership Interest
Transform Holdco LLC	Parent Corporation/Owner	3333 Beverly Rd., Hoffman Estates, IL 60179	100%
Transform KM LLC	Pharmacy Owner/Provider	3333 Beverly Rd., Hoffman Estates, IL 60179	0%
Robert A. Riecker	Chief Financial Officer and Co-Chief Executive Officer	3333 Beverly Rd., Hoffman Estates, IL 60179	0%
Leena Munjal	Chief Digital Officer and Co-Chief Executive Officer	3333 Beverly Rd., Hoffman Estates, IL 60179	0%
Greg Ladley	President, Softlines and Co-Chief Executive Officer	3333 Beverly Rd., Hoffman Estates, IL 60179	0%
Jennifer Speares Lehman	Head of Pharmacy	3333 Beverly Rd., Hoffman Estates, IL 60179	0%

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, JENNIFER SPEARES LEHMAN

Responsible Person of KMART PHARMACY #3592

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

JENNIFER SPEARES LEHMAN
Print Name of Authorized Person

03/26/2019
Date

Managing Pharmacist

Pharmacist Name: LYNNA HO License #: 16983

Pharmacy Name: KMART PHARMACY #3592

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☒
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☒
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Signature _____ Date 3/7/19

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE
for a Pharmacy or Wholesaler located in Nevada

Date 3/7/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 Retail Pharmacy
Nature of Pharmacy or Wholesaler

Kmart Pharmacy 5051 E. Bonanza Rd Las Vegas NV 89110
Name and Address of Business for Which Designated Representative Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name Ho | First Name Lynna | Middle Name H.

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

Present Residence Address-Street or RFD: [redacted] Frittata Ave. | City: Las Vegas NV 89113 | State/Zip | Dates: Dec 2013 to Present

Present Business Address: 5051 E Bonanza Rd | City: Las Vegas NV 89110 | State/Zip | Dates: June 2011 to Present

Present Position with the Pharmacy or Wholesaler: Pharmacy Manager

Phone: Residence | Business 702 459 1003

Date of Birth: [redacted] | Place of Birth (City, County, State): Ho chi Minh City VIETNAM

Age: 40 | Social Security Number: [redacted] | Sex: Female

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Brown	Black	Fair	105 lbs	Small	5'2"

Scars, tattoos or distinguishing marks and/or characteristics No

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

If naturalized, certificate No Not Accessable Date

Place Toledo, Ohio (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial LH

MARITAL INFORMATION-Continued

A. **Current Marriage** 4/18/14 (Date) Las Vegas Clark NV (City, County and)

Spouse's full name (Maiden) John Vu Tran S.S. No

Date of Birth Place of Birth Witchita Kansas

Resident address Frittata Ave. (Street) Las Vegas (City) NV (State) 89113 (Zip)

Telephone: Residence Business 702 929 2229

Spouse's employer SOUTHWEST Pharmacy Occupation Pharmacist

Address of employer 4550 E Bonanza Rd Ste C (Street) Las Vegas (City) NV (State) 89110 (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
John Vu Tran	3/12/12	LV, NV	Divorce	LV, Clark, NV
Quang Tran	8/14/07	Toledo, OH	Divorce	LV, Clark, NV

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

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Ethan Ho Tran		Las Vegas NV	Frittata Ave LV NV 89113
Kayla Ho Tran		Las Vegas NV	Frittata Ave LV NV 89113
Tyler and Parker Tran		Las Vegas NV	Frittata Ave LV NV 89113

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 WT

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, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Calvin Ho		South Ave Toledo OH 43609	Retired
Mother	Jenny Ho		South Ave Toledo OH 43609	Retired
Father-in-Law	Duy Q Tran	Deceased		
Mother-in-Law	Nhan Vu		S Jones #1043 LV NV 89103	Retired

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
	Courtnie Pham		Riverwood Ct Perrysburg, OH 43551	Pharmacis
Spouse	Albert Pham		Riverwood Ct Perrysburg, OH 43551	Physicia
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Arlington/Westfield/Jones Elementary	Toledo, OH	4/89-6/93	Yes ☒ No ☐
High School	Libbey High School	Toledo, OH	8/93-6/97	Yes ☒ No ☐
College University	University of Toledo	Toledo, OH		Yes ☒ No ☐
Other		Allowed to take college courses while in high school		Yes ☐ No ☐

Type of degree obtained, if any Doctorate in Pharmacy

College or university where obtained University of Toledo

Applicant's initial

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 or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial_____ AM

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
N/A	8-1-08	US Bankruptcy Court District of NV #0818655	LV, Clark, NV	Discharged 11-12-08

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:

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
12/13 – Present	Frittata Ave	Las Vegas	NV
10/08 – 12/13	5137 Espocito Ave	Las Vegas	NV
5/07 – 10/08	11082 Scotscraig Ct	Las Vegas	NV
7/06 – 5/07	7616 Little Crow Ave	Las Vegas	NV
8/06 – 7/06	868 Wood Sorrel lane	Perrysburg	OH
9/01 – 8/06	1581 South Ave	Toledo	OH
6/90 – 9/01	610 Western Ave	Toledo	OH
4/89 – 6/90	1745 South Ave	Toledo	OH

Applicant's initial KH

8. EMPLOYMENT:

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
6/11 – Present	Kmart Pharmacy 5051 E Bonanza Rd	13,900 hrs
Title	Description of Duties	Name of Supervisor
Pharmacy Manager	Dispense & Counsel meds	Jennifer Weber-Roe
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
1/08 – 6/11	CVS 405 W. Russell Rd LV NV 89148	6300 hrs
Title	Description of Duties	Name of Supervisor
Pharmacy Manager	Dispense & Counsel Meds	Ke Kim
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial ____________

9. 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 Hung Ly	Home	Piney Summit	LV	NV 89148		(13 yrs)
Employer CVS	Business	9645 S. Maryland Pkwy	LV	NV 89123	702 896 1283	
Name Hanson Truong	Home	1 W. Camero Ave	LV	NV 89139		(17yrs)
Employer Kmart	Business	5051 E Bonanza Rd	LV	NV 89110	702 459 1023	
Name Richard Do	Home	Foothills Village	Henderson	NV 89102		(14 yrs)
Employer Redhills Dental	Business	9770 S Maryland Pkwy #8	LV	NV 89183	702 4637300	
Name Binh Tran	Home	7 Grand gate Street	LV	NV 89143		(10 yrs)
Employer Healthcare partners	Business	1302 W Craig Rd	N LV	NV 89032	702 657 9533	
Name Enrique Solis	Home	Vedena Pl	LV	NV 89113		(12 yrs)
Employer CVS	Business	3557 S Rainbow	LV	NV 89103	702 252 5702	

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 of 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 for any reason whatsoever? Yes ☐ No ☑

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

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

Applicant's initial _____

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 ☑

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 ☑

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/or controlled substances? Yes ☐ No ☑

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 close of a wholesaler Yes ☐ No ☑

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler? Yes ☑ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☑ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes ☑ No ☐

Date of photograph 3/8/19

Applicant's initial

STATE OF Nevada

ss.

COUNTY OF Clark

I, Lynna Ho, 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 case for denial or revocation of a wholesaler 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

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 wholesaler in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 8th day of March 2019

Notary Public

GABRIELA SOLIS
NOTARY PUBLIC
STATE OF NEVADA
COUNTY OF CLARK
My Comm. Exp. 08-25-2020
Certificate No. 17-1577-1

(seal)

Applicant's initial

ADDITIONAL INFORMATION

Applicant's initial.....

pharmacy
care beyond the counter™

NV BOP
431 W PLUMB LANE
RENO, NV 89509

We are writing to inform you that Sears Holdings, owner of Kmart Corporation, has emerged out of bankruptcy with the sale of substantially all of Sears Holdings' assets to Transform Holdco LLC. Certain assets, including the pharmacies, will have a delayed closing in order to allow the purchaser to obtain permits. As a result of the transaction, the pharmacy's owner will be Transform KM LLC, Federal Tax ID 83-3297072, DBA KMART PHARMACY # 3592. As reflected in the enclosed application, two new officers will be added. Two of the current officers will remain the same.

The pharmacy name, location, pharmacist-in-charge and employees will all stay the same.

If at all possible, we are asking that processing of the application be expedited in order to avoid any interruption in care for patients obtaining their medications.

We have enclosed the Change of Ownership application along with the required documentation. If you need anything else please let us know. Thank you for your time.

Sincerely,

Jennifer Speares Lehman
Head of Pharmacy

Transform KM LLC
3333 Beverly Rd BC 260 A
Hoffman Estates, Il 60179

8E

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☑ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Vegas Pharma LLC

Physical Address: 2121 E. Flamingo Rd. Suite 216

City: Las Vegas State: NV Zip Code: 89119

Telephone: _____ Fax: _____

Toll Free Number: _____ E-mail: _____

Website: _____

Managing Pharmacist: Ashley Isom License Number: 17655

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding
	For the application to be complete	☐	☑ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Ashley Isom

Print Name of Authorized Person

4/15/19

Date

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: Jeremy Delk

Business Name: Vegas Pharma LLC

Current Business Address: 2121 E Flamingo Rd Suite 216

City: Las Vegas State: NV Zip Code: 89119

Telephone: Contact Ashley Isom 775-354-6856 Fax: _____

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20191171007

Note: Owner intends for closed door pharmacy to provide on-call service after hours. Pending increasing business hours of operation may increase.

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, Ashley Isom
Responsible Person of Vegas Pharma LLC
hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Ashley Isom
Original Signature of Person Authorized to Submit Application, no copies or stamps

Ashley Isom
Print Name of Authorized Person

4/15/19
Date

Managing Pharmacist

Pharmacist Name: Ashley Isom License #: 17655

Pharmacy Name: Vegas Pharma LLC

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☑	☐
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☑
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☑	☐
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☑	☐

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: NV Date: 1/14/2016 Case #: NV

And/or Criminal Action: State: N/A Date: N/A Case #: N/A

County _____ Court: N/A

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Signature Ashley Isom

4/15/19
Date

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE
for a Pharmacy or Wholesaler located in Nevada

Date 4/15/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 non-sterile compounding pharmacy
Nature of Pharmacy or Wholesaler

Vegas Pharma LLC., 2121 E. Flamingo Rd #216, Las Vegas, NV 89119
Name and Address of Business for Which Designated Representative Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

LSOM (Last Name) ASHLEY (First Name) CHRISTINE (Middle Name)

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

Sandpiper Village Way, Henderson NV 89012 (Present Residence Address-Street or RFD) #732 (City) (State/Zip) Since 01/01/2019

6280 S. Valley View (Present Business Address) Dates Las Vegas NV 89118 (City) since 09/2017 (State/Zip)

Pharmacist perdiem (Present Position with the Pharmacy or Wholesaler) Dates

Phone: Residence

Business 775-354-6856

[redacted] (Date of Birth) Culver City, Los ANGELES, CA (Place of Birth (City, County, State))

42 (Age) [redacted] (Social Security Number) Female (Sex)

Hazel (Color of Eyes) blonde (Color of Hair) fair (Complexion) #120 (Weight) medium (Build) 5'3" (Height)

Scars, tattoos or distinguishing marks and/or characteristics Birthmark on Left upper arm., tattoo on right & left forearm + shoulder

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

If naturalized, certificate No N/A Date

Place N/A (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage** 01/02/2015 (Date) Reno, Washoe, NV (City, County and State)

Spouse's full name (Maiden) Stephen Garr Isom S.S. No

Date of Birth Place of Birth Cedar City, UT

Resident address 219 (Street) Sandpiper Village Way (City) Henderson (State) NV (Zip) 89012

Telephone: Residence 702-884-4277 Business same or 702-914-13[illegible]

Spouse's employer CORF-Pulmonary Rehab Occupation Physical Therapy Assistant

Address of employer 8685 S. Eastern Av. (Street) Suite B (City) LV (State) NV (Zip) 89123

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
Stephen Isom		09/[illegible]/2000	married	LV, NV (Clark Ct
Stephen Isom		04/19/2007	divorced	LV, NV (Clark Cnt
Stephen Isom		01/02/2015	married	Reno, NV (Washoe)

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

Name	Street	City	State	Zip	Telephone
same as above - Remarried Stephen Isom					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
NA			

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

FAMILY INFORMATION-Continued

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

Name .....

Address N/A

Contact person .....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Aloia, Frank deceased		Las Vegas, NV	Retired (deceased)
Mother	Constance Forbes Cornell		Sandpiper Village Way, Henderson 89012	Retired
Father-in-Law	Garth Isom (deceased)		E 7355 S. Washington, UT 84780	Retired Superintendent of schools
Mother-in-Law	Janice Campbell-Isom		Washington, UT 84780	Home maker

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
Brother: Jason Aloia		Lonicera ST Carlsbad, CA	Director of Product Manag for ServiceNow ITSM
~~Spouse~~			
Sister InLaw: Deanna Hodgson-Aloia		Lonicera ST Carlsbad, CA	Graphic Artist
Spouse N/A			
Spouse			
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Pat Diskin Elementary	Las Vegas, NV	1985-1987	Yes ☑ No ☐
High School	Las Vegas Academy	Las Vegas, NV	1994-1995	Yes ☒ No ☐
College / University	1) USN University of Nevada, Las Vegas (now Roseman)	Henderson, NV	2006-2009	Yes ☒ No ☐
~~Other~~	2) UNLV University of Nevada, Las Vegas		2000-2003	Yes ☑ No ☐
	3) UNLV University of Nevada, Las Vegas		1996-2000	Yes [X]

Type of degree obtained, if any 1) PharmD. 2009, 2) MEd. 2003, 3) BS. Kinesiology in 200

College or university where obtained see above

Applicant's initial AL

5 MILITARY INFORMATION:

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

Branch N/A 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 or special or general court martial? N/A Yes ☐ No ☐ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? N/A Yes ☐ No ☐

County N/A State N/A Date registered N/A

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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. List all cases without exception.

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

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes. furnish details on page 10.

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? N/A city, county and state N/A

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

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date
N/A				

Applicant's initial AD

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. List all cases without exception, including bankruptcies:

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

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:

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

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
1/1/2019 - current	Sandpiper Village Way	Henderson	NV 89012
7/15/2016 - 12/31/2018	5970 Sobb Ave	Las Vegas	NV 89118
10/31/2011 - 7/15/2016	2875 Idlewild Dr #109	Reno	NV 89509
1/1/2011 - 10/31/2011	3269 Ogden Rd (Less than one mile away moved within months) Atholl Rd.	Lucerne	CA 95458
5/1/2008 - 12/2010	8815 Murray Canyon Ct	LV.	NV 89156
5/1/2007 - 5/1/2008	5155 W Tropicana #2020	LV	NV 89103
9/1/2000 - 5/1/2007	1765 Mt Hood St	LV	NV 89156
3/1/1996 - 9/1/2000	5155 W. Tropicana #2020	LV	NV 89103
8/1/1995 - 3/1/1996	800 Font Blvd	SF	CA 94132
4/1/1994 - 8/1/1995	5155 W Tropicana #2020	LV	NV 89103
10/31/1985 - 4/1/1993	7237 Pleasant View Ave	LV	NV 8910

Applicant's initial ..... A.J. .....

8. EMPLOYMENT:

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
9/2017 - current	Aeva Pharmacy, 6280 S. Valley View #732, Las Vegas NV	660 hrs
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist (started part time, Now per diem)	mostly: Record keeping, counseling / some: dispensing, filling	Camerina Gamboa
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
2/4/15 - 12/14/15	CVS 285 E Plumb Ln, Reno	1500 hrs
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist full time	dispensing, record keeping	Diego Medina
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
2/2013 - 11/2014	Walmart 4855 Kietzke Ln Reno 89511	3,400 hrs
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist full time	dispensing, record keeping,	Aaron Camp
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
2/2012 - 11/2012	Tahoe Pacific Hospitals Reno NV, 210 W. Liberty St # 310	1440 hrs
Title	**Description of Duties**	**Name of Supervisor**
Clinical Pharmacist full time,	clinical monitoring, dosing, filling, compounding, record keeping, managing	Jim Franco
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
9/2009 - 1/2011	MonteVista - RedRock Hospitals 5900 W Rochelle Av LV NV 89103	2,560 hr
Title	**Description of Duties**	**Name of Supervisor**
Clinical Pharmacist	Clinical monitoring, filling, dispensing, teaching groups	Grant Shetterly RPh Director of Pharmacy
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
5/2009 - 9/2009	MonteVista - RedRock Hosp. 5900 W Rochelle Av. 89103	640 hr
Title	**Description of Duties**	**Name of Supervisor**
Intern Pharmacist	Filling, dispensing, record keeping	Grant Shetterly Director of Pharmacy
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
8/2008 - 5/2009	see attached	1400 hr
Title	**Description of Duties**	**Name of Supervisor**
* Student Intern Pharm.	intern experienced Filling, dispensing, record keeping	Karla Darley USN / Grant Shetterly Director of Pharm
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Number of Employed Hours**
Title	**Description of Duties**	**Name of Supervisor**

* see pg 10

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial .....

9. 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 Tony Spaan Home		2 Trogon Way, LV NV 89103/(				
Employer Teamsters Flamingo Security Business	3555 S. Las Vegas Blvd, LVNV					Over 3C
Name Larry Espadero Home	Director of Chemical Dependency Monte Vista Hos					
Employer Montevista Hospital Business	5900 W. Rochelle Ave, LVNV 89103 (702) 364-1111					5
Name Mindy Hsu Home	2 Humboldt St Reno NV 8950 9 /					10 4
Employer Veteran Affairs Reno NV Business	975 Kirman Av, Reno NV 89502					Pharmac
Name Danielle Fouts Home	3186 S. Maryland Pkwy LV, NV					Nurse
Employer Sunrise Hospital, Nurse Business	7 Pimera Alta St, Las Vegas NV 89178 / 7					7
Name Rick & Debi Novak Home	Moiave Sage Ct, LV, NV 89148					5 + 30+ yrs
Employer Retired Business	Retired nurse and IT specialist Rick & Debi					

* see p.j. 10 if reference on vacation — Alternate references.

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

High School Teacher at Las Vegas High 2003-2006 Sciences
Nevada teaching license with Clark County School Distric

11. Have you ever applied for a city, county of 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.

NA

12. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☒ No ☐

NV BOP 1/14/16 (discipline), and 4/11/19 (approval to be Pharmacy Manag

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☒ No ☐

see above

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

see above

Applicant's initial _____

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 ☒

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 ☐
NV BOP see #12. 12.19

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/or controlled substances? Yes ☐ No ☒

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 close of a wholesaler Yes ☒ No ☐
NV BOP see #12. 12.19

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler? Yes ☒ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☒ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes ☒ No ☐

A:

Date of photograph 4/16/19

Applicant's initial

STATE OF Nevada
ss.

COUNTY OF Clark

I, Ashley Isom, 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 case for denial or revocation of a wholesaler 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 of fraudulent, and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

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 wholesaler in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 1st day of May 2019

Emily Fox ID#548521

Notary Public

(seal)

Applicant's initial

ADDITIONAL INFORMATION

If References on vacation, see alternates:

pg 9.) cont.
Alternate References

Goesel Anson MD.
Ansonthigains & Edwards Plastic Surgery, Las Vegas
C
W 702-822-210 3 Spanish Heights, LVNV 89148
W. Sunset #130 (10+ years)
LVNV 89113

Elizabeth McKenna
Hard Rock Hotel & Casino
C
Las Vegas, NV (10+ years)

FROM PG 6a)

See following pages for previous employment duties/responsibilities

Applicant's initial

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

VEGAS PHARMA LLC

Nevada Business Identification # NV20191171007

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 4, 2019

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law cannot be waived.

SECRETARY OF STATE

STATE OF NEVADA

LIMITED LIABILITY COMPANY CHARTER

I, Barbara K. Cegavske, the Nevada Secretary of State, do hereby certify that **VEGAS PHARMA LLC** did on March 4, 2019, file in this office the Articles of Organization for a Limited Liability Company, that said Articles of Organization is now on file and of record in the office of the Nevada Secretary of State, and further, that said Articles contain all the provisions required by the laws governing Limited Liability Companies in the State of Nevada.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 4, 2019.

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

Certified By: Electronic Filing
Certificate Number: C20190304-2669

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 4/25/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 Non-Sterile Compounding Pharmacy
Nature of License

Vegas Pharma, LLC, 2121 E. Flamingo Rd #216, Las Vegas, NV 89119
Name and Address of Establishment for Which License is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Delk | Jeremy | Steven
Last Name | First Name | Middle Name

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

Hambrick Drive | Nicholasville | KY 40356
Present Residence Address-Street or RFD | City | State/Zip

200 Moore Drive | Dates December 2006 - Present | | |
Present Business Address | City | State/Zip

Investor | Dates April 2001 - Present
Occupation

Phone:
Residence [redacted]
Business 859-887-0013

[redacted] | Clearwater, Pinellas, FL
Date of Birth | Place of Birth (City, County, State)

39 | [redacted] | Male
Age | Social Security Number | Sex

Brown | Brown | Medium | 255 | Athletic | 6'2"
Color of Eyes | Color of Hair | Complexion | Weight | Build | 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.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial.....

A. **Current Marriage** 5/29/10 (Date) Bardstown, Nelson, KY (City, County and State)

Spouse's full name (Maiden) Cynthia Mae Peake S.S. No

Date of Birth Place of Birth Bardstown, KY

Resident address 1160 Hambrick Dr. (Street) Nicholasville (City) KY (State) 40356 (Zip)

Telephone: Residence Business N/A

Spouse's employer N/A Occupation Stay at home mom

Address of employer N/A (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
N/A				

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

Name	Street	City	State	Zip	Telephone
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Graham Harrison Delk	-	Louisville, KY	1160 Hambrick Dr. Nicholasville KY 40356
Ava Collins	- 19	Lexington, KY	1160 Hambrick Dr, Nicholasville, KY 40356

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

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, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Douglas Cornett		Lutheran Church Rd. Bardstown, KY	Retired
Mother	Cheryl Cornett		"	" - Retired
Father-In-Law				
Mother-In-Law				

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	Josh Delk		1 Bernie Trail, Nicholasville, KY 40356	Sales / Snr. Manager
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	St. Joseph	Bardstown, KY	4-8th	Yes ☑ No ☐
High School	Nelson County	" "	'94-'98	Yes ☑ No ☐
College University	Johnson & Wales	Providence, RI	'98-2002	Yes ☑ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any A.S. & B.S.

College or university where obtained Same

Applicant's Initial

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 or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial.....

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
Vet Stem - MediVet		#13CV0498-WG	Poway, CA	7/1/14
10Pearls - Tailor Made Health		#CL-2019-02477	Fairfax, VA	May '19

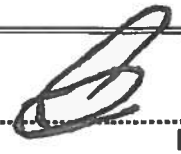
J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
Yes ☑ No ☐ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
Vet Stem - MediVet	#13CV0498-WG	7/1/14
10Pearls - Tailor Made Health	#CL-2019-02477	May 2019

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
9/14-Present:	Hambrick Dr.,	Nicholasville,	KY
4/09-9/14:	158 Deep Springs Dr.,	Bardstown,	KY
4/06-4/09:	15 Richmond Place,	Huntington Station,	NY
1/03-4/05:	285 Willis Ave.,	Manhattan,	NY
1/02-1/03:	54 W 116th 15c Street,	New York,	NY
9/98-1/02:	6216 Smithfield Rd #910,	N. Providence,	RI
1/90-9/98:	1360 Lutheran Church Rd,	Bardstown,	KY

Applicant's initial 

8. 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
2002-Present Delk Enterprises
Title Description of Duties Name of Supervisor
CEO Making major corporate decisions and managing operations

Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
2000 - 2002 Fidelity Invesments
Title Description of Duties Name of Supervisor
Trader mediator between client and the people executing the trades

Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
98 - 2000 Abercrombie & Fitch
Title Description of Duties Name of Supervisor
Sales Associate Improving engagement with merchandise & increase sales

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

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

Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
Title Description of Duties Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial..........................

9. 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 TJ Masterson	Home					
Employer Medivet	Business 200 Moore Dr., Nicholasville, KY 40356 (2012)					
Name Roger Frantz	Home					
Employer Roger F., PSC	Business PO Box 850, Pewee Valley, KY 40056 (2012)					
Name Jerry Fowler	Home					
Employer Jerry F., PLLC	Business 112 N. Spalding Ave., PO Box 1140, LeBannon, KY 40033 (2013)					
Name Steven Wright	Home					
Employer Central Bank	Business 2400 Harrodsburg Rd., Lexington, KY 40503 (2015)					
Name Lawrence Wetherby	Home					
Employer Republic Bank	Business 333 West Vine St., Lexington, KY 40507 (2013)					

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A			

11. 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

KY state

12. Have you ever applied for a city, county of 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.

Yes, shipping license for Tailor Made products to all 50 USA states EXCEPT AR, LA, ME, MS, NC, SC and WV.
-Tailor Made Compounding

Applicant's initial

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☑

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

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

15. 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 ☑

16. 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 ☑

17. 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/or controlled substances? Yes ☐ No ☑

18. 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 close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

Date of photograph 9/25/19

Applicant's initial

STATE OF Kentucky ss.

COUNTY OF Fayette

I, Jeremy Delk, 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 case for denial or revocation of a manufacturer 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

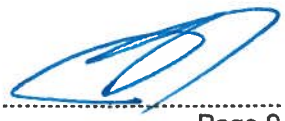
Original Signature of Applicant

Subscribed and Sworn to before me this 25th day of April 2019

Emily Fox #548501

Notary Public

(seal)

Applicant's initial 

ADDITIONAL INFORMATION

Applicant's initial 

9

9A

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH*** *____*
Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*	☐ *Partnership - Pages 1,2,5,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*	☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: BriovaRx Infusion Services 401, LLC.

Physical Address: 4610 Northgate Blvd., Suite 130, Sacramento, CA 95834

Mailing Address: 15529 College Blvd.

City: Lanexa State: KS Zip Code: 66219

Telephone: (916) 648-0124 Fax: (844) 425-0128

Toll Free Number: (877) 698-5415 (Required per NAC 639.708)

E-mail: orxpharmlic@optum.com Website: BriovaRxInfusionServices.com

Managing Pharmacist: Ramona Moenter License Number: PHY53890

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☒	☐ Parenteral **
☐	☒ Internet	☒	☐ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☒	☐ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☒	☐ Sterile Compounding **
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☒	☐ Mail Service Sterile Compounding **
	For the application to be complete	☐	☒ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☒ No ☐

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Edward P. Kramm

Print Name of Authorized Person

4.5.2019

Date

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: California

Parent Company if any: SCP Specialty Infusion, LLC

Mailing Address: 15529 College Blvd

City: Lenexa State: KS Zip: 66219

Telephone: 877-342-9352 Fax: 877-542-9352

Contact Person: Jonathan Reinstatler ; orxpharmlic@optum.com

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) N/A
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. N/A

3) What was the price paid per share? N/A

4) What date did the corporation actually receive the cash assets? N/A

5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: N/A %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:30 pm Saturday Closed am _____ pm

Sunday Closed am _____ pm 24 Hours on call

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Edward P. Kramm

Responsible Person of BriovaRx Infusion Services 401, LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Edward P. Kramm

Print Name of Authorized Person

4.5.2019

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Kansas)
) ss.
Johnson COUNTY)

I, Edward P. Kramm, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the CEO for BriovaRx Infusion Services 401, LLC (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Edward P. Kramm, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name Edward P. Kramm

SUBSCRIBED AND SWORN TO
before me, a notary public this
5 day of April, 2019.

NOTARY PUBLIC

STATE OF KANSAS NOTARY PUBLIC
KIMBERLEY WILLIAMS
My Appointment Expires
August 20, 2020

BriovaRx Infusion Services
15529 College Blvd.,
Lenexa, KS 66219

T 1-877-342-9352
F 1-877-542-9352

April 17, 2019

Nevada State Board of Pharmacy
431 W. Plumb Lane
Reno, NV 89509

Re: BriovaRx Infusion Services 401, LLC.
4610 Northgate Blvd. Suite 130
Sacramento, CA 95834

Disciplinary History Letter

To Whom It May Concern:

Corporate Secretary, Karen E. Peterson, paid a fine to the Oregon Board of Pharmacy in 1998 to settle a discipline related to a prescription misfill. The settlement is not available on the Board's website and she is unable to locate a copy. Ms. Peterson no longer works in this capacity for the Company.

The Kentucky Board of Pharmacy issued a fine against Edward P. Kramm as a pharmacist for failing to complete all required hours of continuing education for 2013. A settlement was signed and Mr. Kramm paid a $500 fine. Mr. Kramm no longer works in this capacity for the company.

Please contact me, at (877) 342-9352 or ORxPharmLic@optum.com if you have any questions or requests for additional information.

Sincerely,

Edward P. Kramm
Chief Executive Officer

Owner: (100%)
SCP Specialty Infusion,LLC.
15529 College Blvd.
Lenexa, KS 66219

BriovaRx Infusion Services 401, LLC
4610 Northgate Blvd., Suite 130
Sacramento, CA 95834

List of Officers and Directors

Individual	Title
Edward Paul Kramm	Director, CEO
Robert Worth Oberrender	Treasurer
Karen Elizabeth Peterson	Secretary
Heather Anastasia Lang Jacobsen	Assistant Secretary
David John Oberg	Assistant Secretary
David John Maurer	Vice President
Michael Gerard Zeglinski	Vice President
Edward Andrew Lagerstrom	Director
Jeffrey David Grosklags	Director

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED ARE TRUE AND CORRECT COPIES OF ALL DOCUMENTS ON FILE OF "SCP SPECIALTY INFUSION, LLC" AS RECEIVED AND FILED IN THIS OFFICE.

THE FOLLOWING DOCUMENTS HAVE BEEN CERTIFIED:

CERTIFICATE OF FORMATION, FILED THE FIFTEENTH DAY OF JANUARY, A.D. 2010, AT 2:24 O'CLOCK P.M.

AND I DO HEREBY FURTHER CERTIFY THAT THE AFORESAID CERTIFICATES ARE THE ONLY CERTIFICATES ON RECORD OF THE AFORESAID LIMITED LIABILITY COMPANY, "SCP SPECIALTY INFUSION, LLC".

Jeffrey W. Bullock, Secretary of State

4777745 8100H

100675756

AUTHENTICATION: 8066905

DATE: 06-21-10

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 02:36 PM 01/15/2010
FILED 02:24 PM 01/15/2010
SRV 100044035 - 4777745 FILE

CERTIFICATE OF FORMATION

OF

SCP SPECIALTY INFUSION, LLC

This Certificate of Formation of SCP Specialty Infusion, LLC (the "Company"), is executed by the undersigned for the purpose of forming a limited liability company pursuant to the Delaware Limited Liability Company Act.

1. The name of the Company is SCP Specialty Infusion, LLC.

2. The address of the registered office of the Company in Delaware is 1209 Orange Street, Wilmington Delaware 19801, New Castle County. The name of the Company's registered agent at that address is The Corporation Trust Company.

3. The Company shall have perpetual existence.

IN WITNESS WHEREOF, the undersigned, an authorized person of the Company, has caused this Certificate of Formation to be duly executed as of the 15th day of January, 2010.

Michael J. Weisberg

Michael J. Weisberg, Organizer

State of California
Secretary of State

CERTIFICATE OF REGISTRATION

I, ALEX PADILLA, Secretary of State of the State of California, hereby certify:

That on the **20th** day of **September, 2017, SCP SPECIALTY INFUSION, LLC,** complied with the requirements of California law in effect on that date for the purpose of registering to transact intrastate business in the State of California; and further purports to be a limited liability company organized and existing under the laws of **Delaware** as **SCP SPECIALTY INFUSION, LLC** and that as of said date said limited liability company became and now is duly registered and authorized to transact intrastate business in the State of California, subject, however, to any licensing requirements otherwise imposed by the laws of this State.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of September 21, 2017.

ALEX PADILLA
Secretary of State

AKP

NP-25 (REV 01/2015)

9B

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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 Pharmacy* or ☑ ***Ownership Change*** *(Provide current license number if making changes:* **PH** 02851

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: MILLER'S OF WYCKOFF

Physical Address: 678 WYCKOFF AVE

Mailing Address: _____

City: WYCKOFF State: NJ Zip Code: 07481

Telephone: 201-891-3333 Fax: 201-891-6392

Toll Free Number: 888-891-3334 (Required per NAC 639.708)

E-mail: PBOUGH@YOURLIKERX.COM Website: MILLERSPHARMACY.COM (YOURLIKERX.COM)

Managing Pharmacist: DAVID M. MILLER License Number: (NJ) 28RI01608500

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒ ☐	Retail	☐ ☒	Off-site Cognitive Services
☐ ☒	Hospital (# beds ____)	☐ ☒	Parenteral **
☐ ☒	Internet	☐ ☒	Parenteral (outpatient)
☐ ☒	Nuclear	☐ ☒	Outpatient/Discharge
☐ ☒	Ambulatory Surgery Center	☑ ☐	Mail Service
☒ ☐	Community	☐ ☒	Long Term Care
☒ ☐	Other: COMPOUNDING	☒ ☐	Sterile Compounding **
		☒ ☐	Non Sterile Compounding
	All boxes must be checked	☒ ☐	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☐	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Philip J. Kreuger III
Original Signature of Person Authorized to Submit Application, no copies or stamps

PHILIP J. KROUGH IV
Print Name of Authorized Person

11-23-18
Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DELAWARE

Parent Company if any: YOURLIFERX, INC.

Mailing Address: 3529 CROST ST

City: ST. AUGUSTINE State: FL Zip: 32092

Telephone: 717-856-3433 Fax: —

Contact Person: PHIL KEOUGH

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) BARUCH HALPORN 9601 COLLINS AVE, BAL HARBOUR, FL 33154
Name Address

b) PHIL KEOUGH 3529 CROST ST, ST. AUGUSTINE, FL 32092
Name Address

c) —
Name Address

d) —
Name Address

2) Provide the number of shares issued by the corporation. 950,000

3) What was the price paid per share? $0.0001

4) What date did the corporation actually receive the cash assets? 12-20-17

5) Provide a copy of the corporation's stock register evidencing the above information SEE ATTACHED

List any physician shareholders and percentage of ownership.

Name: N/A %: 0

Name: N/A %: 0

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 8 pm Saturday 9 am 4 pm

Sunday CLOSED am pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: —

Must be included with the application for a non publicly traded corporation

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors

SEE ATTACHED

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, PHILIP J. KEOUGH IV

Responsible Person of YOURLIFERX, INC DBA MILLERS OR MYCHART

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Philip J Keough IV

Original Signature of Person Authorized to Submit Application, no copies or stamps

PHILIP J. KEOUGH IV

Print Name of Authorized Person

12-4-18

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF _____)
) ss.
_____COUNTY)

I, PHIL KOOLIAN, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the CEO/PRESIDENT for MILLERS OF MYCHOKE (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, PHIL KOOLIAN, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Phillip Koolian
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
4 day of DECEMBER, 2018.

Renata M. Weiss
NOTARY PUBLIC

RENATA M WEISS
MY COMMISSION EXPIRES
DEC. 01 2020
ORANGE COUNTY, NEW YORK
NOTARY PUBLIC

NEVADA STATE BOARD OF PHARMACY

(Licensee mailing address for window envelope)

THIS STUB IS YOUR RECEIPT

Date: 11/04/2016
Amount: 500.00
License #: PH02851

MILLERS OF WYCKOFF
678 WYCKOFF AVE
WYCKOFF, NJ 07481

(ID Card)

Trim ID Card to fit your wallet

PHARMACY

NEVADA BOARD OF PHARMACY

Expires:10/31/2018
MILLERS OF WYCKOFF
678 WYCKOFF AVE
WYCKOFF, NJ 07481

License #
PH02851
Active

IDENTIFICATION ONLY
DOES NOT MEET POSTING REQUIREMENTS

STATE OF NEVADA
STATE BOARD OF PHARMACY
PHARMACY

License Type: PHARMACY

License #: PH02851

DEA #: BM4899615

THE UNDER-NOTED HAVING PAID STATUTORY FEE IS HEREBY LICENCED

Expires: 10/31/2018
STATUS: Active

MILLERS OF WYCKOFF
678 WYCKOFF AVE
WYCKOFF, NJ 07481

NONTRANSFERABLE
POST THIS LICENSE PROMINENTLY IN A CONSPICUOUS PLACE

State Of New Jersey
New Jersey Office of the Attorney General
Division of Consumer Affairs

THIS IS TO CERTIFY THAT THE
Board of Pharmacy

HAS LICENSED

MILLERS OF WYCKOFF INC
DAVID M MILLER
678 WYCKOFF AVE
WYCKOFF NJ 07481-1430

FOR PRACTICE IN NEW JERSEY AS A(N): Pharmacy

06/06/2018 TO 06/30/2019
VALID

28RS00529600
LICENSE/REGISTRATION/CERTIFICATION #

Signature of Licensee/Registrant/Certificate Holder

ACTING DIRECTOR

NEW JERSEY DIVISION OF CONSUMER AFFAIRS

Paul R. Rodrí
Acting Dir
Rea

License Information

Accurate as of November 29, 2018 12:13 PM

Return to Search Results

Name: MILLERS OF WYCKOFF INC

Address: WYCKOFF,NJ

Profession/License Type: Pharmacy,Pharmacy

License No: 28RS00529600

License Status: Active

Status Change Reason:

Issue Date: 4/10/1996

Expiration Date: 6/30/2019

Board Action: YES*

Please visit DCA's website to see the final disposition documents.

* A "YES" in the "Board Action" field indicates that the licensee has a public record of some form of action on file with the Board/Committee. Board actions may come in the form of a Cor and Desist Order, Interim Order, Reprimand, a finalized Uniform Penalty Letter, agreed upon Settlement Letter or Final Order. In some instances, "Yes" will represent that a public record such as an Administrative Complaint or a Provisional Order of Discipline may have been filed with the Board/Committee. Such documents represent the filing of allegations by the Attorn not represent a finding of misconduct until the matter is adjudicated by the Board. Contact the Board/Committee directly to obtain a copy of such documents.

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF REVENUE AND ENTERPRISE SERVICES
SHORT FORM STANDING

MILLERS OF WYCKOFF, INC.
6085010000

I, the Treasurer of the State of New Jersey, do hereby certify that the above-named New Jersey Domestic For-Profit Corporation was registered by this office on January 02, 1957.

As of the date of this certificate, said business continues as an active business in good standing in the State of New Jersey, and its Annual Reports are current.

I further certify that the registered agent and office are:

DAVID MILLER
678 WYCKOFF AVE
WYCKOFF, NJ 07481

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my Official Seal at Trenton, this 13th day of September, 2018

Elizabeth Maher Muoio
State Treasurer

Certificate Number : 6091219667

Verify this certificate online at

https://www1.state.nj.us/TYTR_StandingCert/JSP/Verify_Cert.jsp

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BM4899615	01-31-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	RETAIL PHARMACY-COLLECTOR	12-05-2016

MILLERS OF WYCKOFF INC
678 WYCKOFF AVE
WYCKOFF, NJ 07481-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BM4899615	01-31-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	RETAIL PHARMACY-COLLECTOR	12-05-2016

MILLERS OF WYCKOFF INC
678 WYCKOFF AVE
WYCKOFF, NJ 07481-0000

m DEA-223 (9/2016)

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF "YOURLIFERX, INC.", FILED IN THIS OFFICE ON THE TWENTIETH DAY OF DECEMBER, A.D. 2017, AT 12:40 O`CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

Jeffrey W. Bullock, Secretary of State

6671413 8100
SR# 20177685999

Authentication: 203800773
Date: 12-20-17

You may verify this certificate online at corp.delaware.gov/authver.shtml

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
Board of Pharmacy
124 Halsey Street, 6th Floor, Newark NJ 07102

GURBIR S. GREWAL
Attorney General

PAUL R. RODRÍGUEZ
Acting Director

Mailing Address:
P.O. Box 45013
Newark, NJ 07101
(973) 504-6450

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

August 30, 2018

David Miller, RPIC
Millers of Wyckoff Pharmacy
678 Wyckoff Avenue
Wyckoff, New Jersey 07481

Re: Inspection #8-2498-17-160
Date of Inspection: 3/1/17

Dear Mr. Miller:

After affording you an opportunity to discuss the above-referenced matter with the New Jersey State Board of Pharmacy on August 22, 2018, the Board has decided to remove citation N.J.A.C.13:39-11.16(a) and mitigate citation N.J.A.C.13:39-11.24(a)10 to a Warning.

Please complete the attached **Certification** form and submit **$1,000.00** for fines incurred to the Board within 15 days receipt of this letter.

NEW JERSEY STATE BOARD OF PHARMACY

By:
Anthony Rubinaccio, RPh
Executive Director

AR/rh
(8/17)

CERTIFICATION

I, David Miller, hereby acknowledge that I have read and reviewed the Board's letter dated August 30, 2018 regarding allegations of violations of the Board's enabling act and/or regulations.

Please Check One:

[✓] I acknowledge the conduct which has been charged and agree to:

Cease and desist from engaging in the conduct alleged and pay a penalty in the amount of $1,000.00 (to be paid upon signing of this Certification).

I am also aware that the action taken against me by the Board herein is a matter of public record, and that the Board's letter and this Certification are public documents.

(Signature)

Dated: 9/4/18

David Miller

(Print Name)

Ref: David Miller, RPIC
Millers of Wyckoff Pharmacy
678 Wyckoff Avenue
Wyckoff, NJ 07481
(28RS00529600)
Inspection #8-2498-17-160

AR/rh
(8/17)

ATTACHMENT A

Millers of Wyckoff Pharmacy – 678 Wyckoff Avenue, Wyckoff, New Jersey 07481
Pharmacist-In-Charge: David Miller
Bureau File #8-2498-17-160, Period: 3/1/17
Reference: Board of Pharmacy inspection conducted per N.J.S.A.45:1-18 and N.J.S.A.45:14-48(a)11&12, and a memorandum, dated February 6, 2017 from Anthony Rubinaccio, Executive Director, Board of Pharmacy, to Edward Tumminello, Chief, Enforcement Bureau, requesting an inspection for the subject pharmacy in connection with an application for a **Remodeling**.

Details

CITE	DESCRIPTION	FINE
N.J.A.C.13:39-11.24(a)10	When test result indicated that the cleanroom did not meet the standards established, the pharmacy failed to immediately cease using the cleanroom that was out of compliance until such time that the cleanroom met the requisite standards.	Warning
N.J.A.C.13:39-11A.9(g)	During the compounding of hormonal products, the pharmacy failed to adhere to standards establish by the Occupational Safety and Health Administration (OSHA): Specifically, most commonly compounded non-sterile preparation are hormonal related products, in the dosage forms of capsules, creams and ointments. Hazardous Active Pharmaceutical Ingredients (API), such as Progesterone and Testosterone, as well as batch prepared hormonal products, were observed to be stored in the active inventory along with non-hazardous API's.	$1,000.00
TOTAL: $1,000.00		

9C

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☒ *Partnership - Pages 1,2,5,7*
☐ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Premier Specialty Infusion, LLC

Physical Address: 2401 Hassell Rd Ste 1525

Mailing Address: 2401 Hassell Rd. Ste 1525

City: Hoffman Estates State: ILLINOIS Zip Code: 60169

Telephone: 800-783-9655 Fax: 877-770-4179

Toll Free Number: 800-783-9655 (Required per NAC 639.708)

E-mail: scott.luckow@psinfusion.com Website: www.psinfusion.com

Managing Pharmacist: Scott Luckow License Number: 51.041005

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☒ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral **
☐	☒ Internet	☒	☐ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☐	☒ Mail Service
☒	☐ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☐	☒ Sterile Compounding **
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☐	☒ Mail Service Sterile Compounding **
	For the application to be complete	☐	☒ Other Services: _____

****If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Scott

Original Signature of Person Authorized to Submit Application, no copies or stamps

Scott Luckow

Print Name of Authorized Person

10/23/18

Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General ____ Limited ✓

Partnership Name: Premier Specialty Infusion LLC

Mailing Address: 2401 Hassell Rd Ste 1525

City: Hoffman Estates State: IL Zip Code: 60169

Telephone Number: 800·783·9655 Fax Number: 877-770-4179

Contact Person: Scott Luckow

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

Name	G or (L)	Percentage
Ambreen Vafri	L	97%
Scott Luckow	L	3%

List names of 4 largest partners and percentage of ownership:

Name: N/A %: ____

Name: ____ %: ____

Name: ____ %: ____

Name: ____ %: ____

List any physician shareholders and percentage of ownership.

Name: N/A %: ____

Name: ____ %: ____

Name: ____ %: ____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:00 pm Saturday 24 am 7 pm

Sunday 24 am 7 by phone pm 24 Hours ____ by phone

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: N/A

Business Name: _____

Current Business Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday N/A am _____ pm Saturday N/A am _____ pm

Sunday N/A am _____ pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Scott Luckow

Responsible Person of Premier Specialty Infusion LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Scott

Original Signature of Person Authorized to Submit Application, no copies or stamps

Scott Luckow

Print Name of Authorized Person

10/23/18

Date

Include with the Application for Authority to Dispense Drugs

Practitioner Dispensing
Controlled Substance Waiver Form

Each dispensing practitioner must complete this form. Do not submit for a group.

Print Name: Premier Specialty Infusion, LLC

Address: 2401 Hassell Rd Ste. 1525

City: Hoffman Estates State: IL Zip: 60169

Telephone: 800-783-9655

_____ I will be dispensing controlled substances at the address listed above and I understand that I am required and submit data to the Prescription Controlled Substance Abuse Prevention Task Force weekly as required by NAC 639.745 [1(f)].

__X__ I will not be dispensing controlled substances at the address listed above. If I choose to dispense controlled substances in the future, I must contact the Nevada State Board of Pharmacy to modify my license.

By signing and dating this waiver form, I certify that the information provided is true.

Original Signature of Dispensing Practitioner

10/23/18
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ILLINOIS)
) ss.
KANE COUNTY)

AILEEN M WARREN
Official Seal
Notary Public – State of Illinois
My Commission Expires Jan 25, 2021

I, Scott Luckow, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Pharmacist In Charge for Premier Specialty Infusion (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Scott Luckow, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Scott
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
23 day of October, 2018.

Aileen M Warren
NOTARY PUBLIC

AILEEN M WARREN
Official Seal
Notary Public – State of Illinois
My Commission Expires Jan 25, 2021

Premier
SPECIALTY INFUSION

To Whom It May Concern:

Below is a list containing the Name, Date of Birth, and Address of All Corporate Officers, Partners or Owner(s):

Scott Luckow

Pharmacy Manager, PIC, Owner

W437 Bode Rd

Elgin, IL 60120

DOB: 5

Ambreen Jafri

Pharmacy Owner, Partner

' Lake Adalyn Drive

South Barrington, IL 60010

DOB:

Thank you,

Premier Specialty Infusion

2401 W Hassell Rd, Suite 1525

Hoffman Estate, IL 60169

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "PREMIER SPECIALTY INFUSION, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SEVENTEENTH DAY OF OCTOBER, A.D. 2018.

Jeffrey W. Bullock, Secretary of State

6225542 8300

SR# 20187166020

Authentication: 203631232

Date: 10-17-18

You may verify this certificate online at corp.delaware.gov/authver.shtml

File Number 0616916-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

PREMIER SPECIALTY INFUSION, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 06, 2017, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* NOVEMBER *A.D.* 2018 .

SEAL OF THE STATE OF ILLINOIS — AUG. 26TH 1818

Authentication #: 1831202040 verifiable until 11/08/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Premier
SPECIALTY INFUSION

COPY

Sent to:
DFPR
10.17.18
copy of check attached

October 16, 2018

To Whom It May Concern,

We are pursuing an out of state pharmacy license and need to request an **Illinois Certification of Licensure** for our Pharmacy.

Premier Specialty Infusion LLC
2401 Hassell Rd. Ste 1525
Hoffman Estates, IL 60169

License#: 054.020273 - Active
Issued: 04/20/2017
Expires: 03/31/2020
Method of Licensure: Paper
Disciplinary Action: N

Please send the above Illinois Certification of Licensure to:

Nevada State Board of Pharmacy
431 W Plum Lane
Reno, NV 89509

Thank you,

Aileen Warren, PharmD, RPh
Director Of Operations
Aileen.warren@psinfusion.com
800-783-9655

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
054.020273
051.041005

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES:
03/31/2020

LICENSED PHARMACY

COMMUNITY

PREMIER SPECIALTY INFUSION LLC
SCOTT LUCKOW
2401 HASSELL RD STE 1525
HOFFMAN ESTATES, IL 60169-2000

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

12389962

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4052203

9D

410

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Pharmacy* or ☐ ***Ownership Change*** *(Provide current license number if making changes:* ***PH____***

Check box below for type of ownership and complete all required forms.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Westmoreland Pharmacy, Inc.

Physical Address: 1945 State St. STE 100

Mailing Address: 1945 State St. STE 100

City: New Albany State: IN Zip Code: 47150

Telephone: 812-944-6500 Fax: 812-944-6900

Toll Free Number: 1-866-944-6505 (Required per NAC 639.708)

E-mail: info@westmorelandpharmacy.com Website: www.westmorelandpharmacy.com

Managing Pharmacist: Anthony Westmoreland License Number: 26017456A

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒ ☐	Retail	☐ ☒	Off-site Cognitive Services
☐ ☒	Hospital (# beds ____)	☐ ☒	Parenteral **
☐ ☒	Internet	☐ ☒	Parenteral (outpatient)
☐ ☒	Nuclear	☐ ☒	Outpatient/Discharge
☐ ☒	Ambulatory Surgery Center	☒ ☐	Mail Service
☒ ☐	Community	☐ ☒	Long Term Care
☐ ☒	Other: _____	☐ ☒	Sterile Compounding **
		☒ ☐	Non Sterile Compounding
	All boxes must be checked	☐ ☒	Mail Service Sterile Compounding **
	For the application to be complete	☐ ☒	Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☒ No ☐

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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 pharmacy 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.

Anthony Westmoreland

Original Signature of Person Authorized to Submit Application, no copies or stamps

Anthony Westmoreland — Print Name of Authorized Person

03/28/2019 — Date

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Indiana

Parent Company if any: _____

Mailing Address: 1945 State St. STE 100

City: New Albany State: IN Zip: 47150

Telephone: 812-944-6500 Fax: 812-944-6900

Contact Person: _____

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) Anthony Westmoreland 12307 Hummingbird Way Sellersburg, IN 47172
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 100

3) What was the price paid per share? $1

4) What date did the corporation actually receive the cash assets? 08/26/2005

5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: n/a %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:30 am 7:00 pm Saturday 8:30 am 2:00 pm

Sunday n/a am n/a pm 24 Hours n/a

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: _____

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

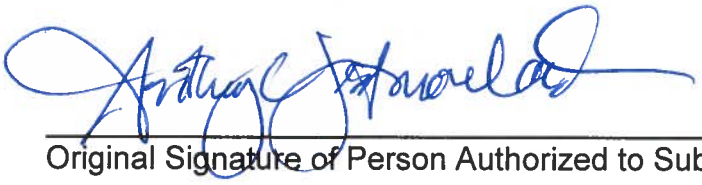
I, Anthony Westmoreland

Responsible Person of Westmoreland Pharmacy, Inc.

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.



Original Signature of Person Authorized to Submit Application, no copies or stamps

Anthony Westmoreland
Print Name of Authorized Person

03/28/2019
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Indiana)
) ss.
Floyd COUNTY)

I, Anthony Westmoreland, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the owner/president for Westmoreland Pharmacy, Inc. (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Anthony Westmoreland, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
28 day of March, 20 19.

NOTARY PUBLIC

RB Smith
Notary Public, State of Indiana
Floyd County
Commission Number NP0719050
My Commission Expires
March 6, 2027

Your order has been submitted and all fees have been applied to your credit card. If you ordered a card, please allow 5 - 10 business days to receive your order in the mail.

If you selected **Free Certificate Printout** click **Print Receipt** at the bottom of the page. This page serves as your certificate and can be used to satisfy any legal posting requirements.

Official License Record

State of Indiana
Official License Record

Full Name: Anthony L Westmoreland
License Number: 26017456A
License Type: Pharmacist
License Status: Active
Issue Date: 10/23/1991
Expiration Date 6/30/2020

Order Information

Date Submitted:	1 June 2018
Applicant Name:	Anthony L Westmoreland
License Number:	26017456A
Agency:	HPB
Process:	Duplicate License process

Payment Information

Authorization Code:	
Received Date:	
Transaction #:	
Credit Card Number:	
Fee Amount:	$0.00
ServiceFee:	$2.50
Instant Fee:	$0.00
Total Fee:	$0.00

WESTMORELAND
PHARMACY + COMPOUNDING

1945 State Street • New Albany, IN 47150 • Ph: 812.944.6500 Fax: 812.944.6900

List of Officers and Directors:

Anthony Westmoreland, Owner/ President

WESTMORELAND
PHARMACY + COMPOUNDING

1945 State Street • New Albany, IN 47150 • Ph: 812.944.6500 Fax: 812.944.6900

Westmoreland Pharmacy, Inc. Stock Register:

On August 26, 2005 100 shares of Westmoreland Pharmacy stock were created and sold to Anthony Westmoreland for one dollar per share.

Indiana Professional Licensing Agency

402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Phone: (317) 234-3031
Website: PLA.IN.gov

Michael R. Pence, Governor
Nicholas W. Rhoad, Executive Director

DATE: 09-04-2014

TO: Consumer Protection Division, Attorney General's Office

FROM: Deborah Frye, Compliance, IPLA

SUBJECT: Westmoreland Pharmacy 60005924A 2125 State St. New Albany, IN 47150

The Assistant Director of the Indiana Board of Pharmacy by a pharmacist regarding the compounding Domperidone for human use. The pharmacist was presented with a prescription for oral Domperidone by a patient, he informed them that the product was not available in the US. The patient said that she had been getting it in the hospital and it was compounded by Westmoreland Pharmacy in New Albany. The other question posed by the pharmacist was whether a pharmacy could compound a product and sell it to another pharmacy to be dispensed. Compounded prescriptions are written for a specific patient by a physician and dispensed directly to that patient. The FDA considers this a product that should not be compounded for use in the United States. We would like this information brought before the Indiana Board of Pharmacy for their consideration.

STATE OF INDIANA
OFFICE OF THE INDIANA ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION
302 W. WASHINGTON STREET, 5TH FLOOR • INDIANAPOLIS, IN 46204-2770
www.IndianaConsumer.com

GREG ZOELLER
INDIANA ATTORNEY GENERAL

PHONE: 317.232.6330
FAX: 317.233.4393

September 17, 2014

Westmoreland Pharmacy
2125 State Street
New Albany, IN 47150

Re: File No. 14-CP-60146 Indiana Professional Licensing Agency vs. Westmoreland Pharmacy

Dear Westmoreland Pharmacy:

Enclosed is a copy of a complaint received by the Licensing Enforcement & Homeowner Protection Unit ("Unit"). Indiana law requires the Unit to investigate complaints against licensed professionals and deceptive acts in connection with real estate transactions. The Unit also investigates complaints concerning the unlicensed practice of professions regulated under Title 25.

You may provide a written response within **twenty (20) days** of the date of this letter. You may submit your response via e-mail or fax

Please include the following information in your response:

1. The file number shown above;
2. My name, Audrea Racine
3. Your explanation of what happened;

If your written response is not received within the above-mentioned time period, the investigation will continue without the benefit of your input.

You will be advised of the final disposition of the investigation once it is completed. If you have any further questions, do not hesitate to contact me.

Sincerely,

Audrea Racine

Audrea Racine
Case Analyst
audrea.racine@atg.in.gov

Westmoreland PHARMACY

Office of the Indiana Attorney General

Indianapolis, IN 46204

October 6, 2014

Re: File No. 14-CP-60146

Dear Ms. Racine,

I am writing in response to the attached complaint your office sent to me on September 17, 2014 regarding Domperidone.

On or around the beginning of this year, 2014, our pharmacy was contacted by the local hospital – Floyd Memorial Hospital and Health Services in New Albany, IN. The pharmacy stated that they had been getting Domperidone oral capsules compounded for in-patient use by a local compounding pharmacy in New Albany. But apparently that pharmacy could no longer supply it. The hospital uses Domperidone for particularly resistant cases of gastroparesis as prescribed by attending Gastroenterologists. The Hospital asked if we could begin supplying the Domperidone to them. Our pharmacy responded that we would have to try and source the chemical first and let them know. We contacted CBS Chemical in Phoenix, AZ and they agreed to provide the product to us.

Once we received the chemical, our pharmacy began supplying Domperidone 10mg capsules to the hospital for in-patient use. Also, we began to see prescriptions for patients once they left the hospital. We filled these prescriptions for home use.

Your letter came with great concern. We immediately researched and understood the validity of the complaint. The fact that this drug requires an IND in the U.S. in order to be dispensed became apparent to us. Our pharmacy takes great pride in complying with rules and regulations. We have previously been accredited by the Pharmacy Compounding Accreditation Board. We realized the significance of our actions. Thus, immediately we did the following:

1. Ceased and desisted in dispensing further Rx's for Domperidone in any form.

2125 State Street #17 . New Albany, IN 47150 . (t) 812.944.6500 (f)812.944.6900 (e) mypharmacy@insightbb.com

Westmoreland PHARMACY

2. Contacted patients and Providers to notify them we would no longer be able to provide Domperidone.
3. Quarantined all Domperidone chemical and readied for reverse distribution.
4. Updated our pharmacy SOP to include a section "Determining drugs that are legal to compound".
5. Advising all staff of the events and making it mandatory to sign off on the new SOP section.

As I stated earlier, we take these matters seriously. We hope our actions, in response, have been a good faith effort to correct our deficiency. Please let us know what additional steps, if any, we need to take to resolve this situation.

Sincerely,

Anthony L. Westmoreland

Anthony L. Westmoreland, RPh

Westmoreland Pharmacy Inc.

2125 State Street #17 . New Albany, IN 47150 . (t) 812.944.6500 (f)812.944.6900 (e) mypharmacy@insightbb.com

BEFORE THE INDIANA
BOARD OF PHARMACY
CAUSE NUMBER: 2015 IBP 0053

IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF	)
	)
WESTMORELAND PHARMACY, INC.	)
LICENSE NO.: 60005924A	)

HEARING NOTICE

Comes now the INDIANA BOARD OF PHARMACY ("Board") pursuant to Ind. Code § 4-21.5-3-20 and issues the following Hearing Notice:

1. This notice is being provided to Westmoreland Pharmacy, Inc. ("Respondent"), 2125 State Street, New Albany, Indiana 47150.
2. This notice is being provided to counsel for State of Indiana, N. Renee Gallagher, Deputy Attorney General, Office of the Attorney General, Indiana Government Center South, 5th floor, Indianapolis, Indiana 46204, telephone number (317) 234-7114.
3. The official cause number of this action is: 2015 IBP 0053.
4. This hearing is to address the issues raised in the Complaint, which is attached hereto as **Exhibit A.**
5. A hearing regarding this matter will be held on **February 8, 2016, at 1:30 p.m.**, Eastern Standard Time, in the Indiana Government Center South, Room W064, located at 402 West Washington Street, Indianapolis, Indiana 46204.
6. The Board is empowered to hold this disciplinary hearing pursuant to the authority of Ind. Code § 25-1-9 and Ind. Code § 4-21.5 *et seq*.
7. The Board will be presiding as administrative law judge in this matter. Theodore Cotterill, Director of the Board, may be contacted to obtain information concerning

CERTIFICATE OF SERVICE

I certify that a copy of the "Hearing Notice" has been duly served upon:

Westmoreland Pharmacy, Inc.
2125 State Street
New Albany, Indiana 47150
Service by U.S. Mail

N. Renee Gallagher
Deputy Attorney General
Office of the Attorney General
Indiana Government Center South
402 West Washington Street, 5th Floor
Indianapolis, Indiana 46204
Service by E-mail

January 25, 2016
Date

Theodore C. Cotterill, Director
Indiana Board of Pharmacy

Indiana Board of Pharmacy
Indiana Government Center South
402 West Washington St., Room W072
Indianapolis, Indiana 46204
Phone: 317-234-2067
Fax: 317-233-4236
Email: pla4@pla.in.gov

Explanation of Service Methods
Personal Services: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual's electronic mail address.

BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 2015 IBP 0053

IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF	)
WESTMORELAND PHARMACY, INC.	)
LICENSE NUMBER 60005924A (ACTIVE) (CLOSED DOOR III)	)

FILED
OCT 14 2015
Indiana Professional Licensing Agency

ADMINISTRATIVE COMPLAINT

This complaint is brought against the pharmacy license of Westmoreland Pharmacy, Inc. ("Respondent"), by the Office of the Attorney General, by counsel, Deputy Attorney General Stephanie E. Sluss, on behalf of the State of Indiana ("Petitioner") and pursuant to Ind. Code § 25-1-7-7, Ind. Code § 25-1-5-3, Ind. Code ch. 25-26, the Administrative Orders and Procedures Act, Ind. Code art. 4-21.5 and Ind. Code ch. 25-1-9 and in support alleges and states:

FACTS

1. Respondent is a licensed closed door pharmacy in the State of Indiana having been issued license number 60005924A on or about December 20, 2005. Said license is currently active.

2. Respondent's address of record with the Indiana Professional Licensing Agency is 2125 State Street, New Albany, IN 47150.

3. On or around the beginning of 2014, Respondent began compounding drug products containing Domperidone.

4. Domperidone is a drug used to increase milk production in breastfeeding women, which is not an approved use, and to treat certain gastric disorders.

5. Domperidone is not approved for use in any country for breastfeeding women and only in the United States for use in treating certain gastric disorders under special conditions which are outlined by the FDA.

6. Domperidone was removed from the market by the Food and Drug Administration ("FDA") in 1998 due to serious adverse effects, including irregular heartbeat, stopping of the heart, or sudden death. These dangers could convey to nursing babies of breastfeeding women.

7. In June 2004, the FDA issued a "Talk Paper" warning breastfeeding women not to use Domperidone and issued warning letters to pharmacies that compounded products containing Domperidone and firms that supplied Domperidone for use in compounding.

8. Since June 2004, the FDA has issued several warning letters to pharmacies and firms regarding compounding, supplying or distributing Domperidone.

9. The FDA also issued an "Import Alert" alerting FDA field personnel to watch for imports of Domperidone and to detain and refuse admission as appropriate.

10. In March 2012, the FDA issued another "Import Alert" advising that Domperidone was being imported as a bulk active pharmaceutical ingredient for compounding, and in a finished dosage form. The FDA warned that the importation of Domperidone presents a "public health risk" and violates the FDCA.

11. Domperidone can only be obtained in the United States through the FDA's Expanded Access to Investigational Drugs Program ("IND"), and then only for patients 12 years of age and older with certain gastric disorders.

12. Prior to prescribing or dispensing Domperidone, a health care practitioner must submit an application to the FDA to become a Sponsor-Investigator as part of the IND and the

IND must be in effect prior to the importation, interstate shipment, and administration of Domperidone.

13. To obtain Domperidone, the FDA has authorized only specific suppliers to provide the drug.

14. A health care practitioner who is a Sponsor-Investigator can obtain Domperidone for their patients through either direct import to their office for dispensing from one of the approved manufacturers, or by direct shipment to the patient by the approved pharmacy supplier.

15. Respondent received Domperidone from CBS Chemical in Phoenix, AZ, an unauthorized distributor of Domperidone.

16. Respondent used this bulk product to compound Domperidone for patients with certain gastric disorders and without INDs in place.

17. Respondent supplied a local hospital with Domperidone drug products and also filled prescriptions for individuals to use the drug at home.

18. Respondent indicated that it has ceased compounding Domperidone after receiving a consumer complaint in September of 2014 and conducting independent research on the drug.

COUNT I

19. Paragraphs 1 (one) through 18 (eighteen) are incorporated by reference herein.

20. Respondent violated Ind. Code § 25-1-9-4(a)(4)(A) in that Respondent has continued to practice although it has become unfit to practice due to professional incompetence as evidenced by, which includes but is not limited to, Respondent compounding Domperidone and supplying it to a hospital and individuals.

COUNT II

21. Paragraphs 1 (one) through 18 (eighteen) are incorporated by reference herein.

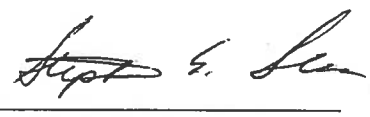
22. Respondent violated Ind. Code § 25-1-9-4(a)(4)(B) in that Respondent has continued to practice although it has become unfit to practice due to failure to keep abreast of current professional theory or practice as evidenced by, which includes but is not limited to, Respondent compounding Domperidone and supplying it to a hospital and individuals.

WHEREFORE, Petitioner demands an order against the Respondent that:

1. Imposes the appropriate disciplinary sanction;
2. Directs Respondent to immediately pay all of the cost incurred in the prosecution of this case;
3. Directs Respondent to pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund pursuant to Ind. Code § 4-6-14-10(b); and
4. Provide any other relief the Board deems just and proper within the premises.

Respectfully submitted,

Gregory F. Zoeller
Attorney General of Indiana
Atty. No. 1958-98

By: 

Stephanie E. Sluss
Deputy Attorney General
Attorney No. 26920-49

California State Board of Pharmacy
1625 North Market Boulevard, Suite N219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

January 19, 2017

CERTIFIED MAIL

WESTMORELAND PHARMACY & COMPOUN
ATTN: ANTHONY WESTMORELAND
1945 STATE ST.
NEW ALBANY, IN 47150

RE: CI 2016 71933
WESTMORELAND PHARMACY & COMPOUNDING
Unlicensed

After thorough and careful consideration of the explanation and information you provided at the office conference, the committee determined that the information presented had been previously considered and was not new information. The committee decided to affirm the above-referenced Citation and Fine, CI 2016 71933 as originally issued.

This decision is the final administrative order regarding the Citation. Since you did not timely request a hearing to contest the Citation pursuant to California Code of Regulations, title 16, section 1775.4, subdivision (a), the administrative appeals process has concluded.

Failure to pay any imposed fine(s) within 30 days of the date of this letter may result in disciplinary action being taken. The timely payment of the imposed fine(s) shall not constitute an admission of the violation(s) charged in the Citation.

If any fine(s) are not timely paid, then the full amount of the unpaid fine(s) shall be added to the fee for the renewal of your license. Your license shall not then be renewed without full payment of the renewal fee and the assessed fine(s).

Please contact Associate Enforcement Analyst Jennifer Sevilla at (916) 574-7925, if you have any questions.

Sincerely

Virginia Herold
Executive Officer
Board of Pharmacy

DECLARATION OF SERVICE BY CERTIFIED MAIL

RE: WESTMORELAND PHARMACY & COMPOUNDING Unlicensed

Citation CI 2016 71933

I declare:

I am employed in the County of Sacramento, California. I am over 18 years of age and not a party to the within entitled cause. My business address is 1625 North Market Boulevard, Suite N219, Sacramento, California 95834-1924.

On January 19, 2017, I served the attached:

Decision letter from office conference.

in said cause, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid by Certified Mail, in the United States mail at Sacramento, California, addresses as follows:

NAME	CERTIFIED MAIL NO
WESTMORELAND PHARMACY & COMPOUNDING ATTN: ANTHONY WESTMORELAND 1945 STATE ST. NEW ALBANY, IN 47150	7016 1370 0000 5640 5975

I declare under penalty of perjury that the forgoing is true and correct.

Executed on January 19, 2017, at Sacramento, California.

DECLARANT

Jennifer Sevilla

Associate Enforcement Analyst

BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 2015 IBP 0053

IN THE MATTER OF THE INDIANA	)
PHARMACY LICENSE OF	)
	)
WESTMORELAND PHARMACY, INC.	)
LICENSE NUMBER 60005924A	)

FINAL ORDER ACCEPTING PROPOSED SETTLEMENT AGREEMENT

The State of Indiana ("Petitioner"), by Amelia A. Hilliker, and Williams Bros. Health Care Pharmacy of Bloomington, Inc. ("Respondent"), signed a "Settlement Agreement" ("Agreement"), filed on April 4, 2017, which purports to resolve all issues involved in the action by the Petitioner and the Indiana Board of Pharmacy ("Board") regarding the Respondent's license, and which Agreement has been submitted to the Board for approval.

The Board after reviewing the Agreement at the April 10, 2017, meeting held in Room W064 of the Indiana Government Center South, 402 West Washington Street, Indianapolis, Indiana 46204, now finds it has been entered into fairly and without fraud, duress, or undue influence, and is fair and equitable between the parties. The Board hereby incorporates the Agreement which is attached hereto and incorporated herein as **Exhibit A**, into this Final Order.

WHEREFORE, the Board hereby accepts and approves the Findings of Facts, Conclusions of Law, and Agreed Disposition presented by the parties and issues this Final Order, by a vote of 6-0:

1. Respondent's Indiana pharmacy license shall be issued **LETTER OF REPRIMAND**, which will be included as a permanent part of Respondent's file located at the Indiana Professional Licensing Agency.

PLEASE SEE ATTACHMENT.

2. Respondent will ensure compounding staff undergo ten (10) hours of continuing education in the areas of FDA Regulations within one (1) year of the date of the Board's Final Order accepting this Agreement and provide proof of completion to the Board.

3. Within thirty (30) days of the date of this Order, Respondent shall, pursuant to I.C. § 4-6-14-10(b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order made payable to the State of Indiana and submitted to the following address:

Indiana Office of the Attorney General
Attn: Teresa Henson
302 W. Washington Street, 5th Floor
Indianapolis, IN 46204

4. A violation of this Final Order, any non-compliance with the statutes or regulations regarding the practice of pharmacy may result in an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to Ind. Code § 25-1-9-4, and or all of which could lead to additional sanctions.

SO ORDERED, this _____ day of February, 2017.

INDIANA BOARD OF PHARMACY

_____
Steve Anderson, R. Ph, Vice President
Indiana Board of Pharmacy

CERTIFICATE OF SERVICE

I certify that a copy of the "Final Order Accepting Proposed Settlement Agreement" has been duly served upon:

Westmoreland Pharmacy, Inc.
c/o Anthony Westmoreland
2125 State Street
New Albany, IN 47150
Service by US Mail

Amelia A. Hilliker
Deputy Attorney General
302 West Washington Street, 5th Floor
Indianapolis, IN 46204
Amelia.Hilliker@atg.in.gov
Service by E-Mail

_____
Date

_____
Litigation Specialist

CONSOLIDATED
SIGN UP TODAY AT PNC REMITTANCE ADVANTAGE HTTPS://RAD
1 MEDICARE'S PAYMENT-THIS MAY INCLUDE THE SEQUESTRAT
2 AMOUNT NON-COVERED IS BASED ON MEDICARE'S EOB OR F

_____
Telephone: 317-234-2067
Email: pla4@pla.in.gov

Explanation of Service Methods
Personal Service: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual's electronic mail address.

WESTMORELAND
PHARMACY • COMPOUNDING

Mailed 1-9-18
to BOP
AW

January 9, 2018

Dear Board of Pharmacy,

Pursuant to the attached Letter of Reprimand that our pharmacy received, please find the REQUIRED 10 HOURS OF CONTINUING EDUCATION PERFORMED BY COMPOUNDING STAFF.

We have 3 compounding staff members that performed the CE:

Anthony Westmoreland PIC

Tahnee Miller RPh Compounding Pharmacist

Randy Bryan Smith CPhT Compounding Technician

If there are any further questions, please feel free to contact me directly at 502-298-9085.

Sincerely,

Anthony Westmoreland RPh

Owner, Westmoreland Pharmacy

CPE Monitor Activity Transcript

Participant Name: Tahnee Lynne Miller — RPh Compounding Pharmacist
NABP e-Profile ID: 278939
CPE Activity Date Range: 11/01/2017 - 01/08/2018
Total CPE Hours Earned: 37.0

Recorded CPE activity for the period of 11/01/2017 to 01/08/2018. Please allow 60 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 60 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

Activity Date	ACPE UAN	Title	Provider	Format	Topic Designators	Contact Hours (CEU)	Live Hours	Home Hours	Activity Type
01/08/2018	0422-0000-17-236-H07-P	Compounding: Managing Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
01/08/2018	0422-0000-17-321-H07-P	Compounding: Sterile Compounding Aseptic Technique	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
01/08/2018	0422-0000-17-325-H07-P	Compounding: Understanding Requirements for Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
01/08/2018	0422-0000-17-327-H07-P	Compounding: Maintaining a Controlled Environment for Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
01/08/2018	0422-0000-17-331-H07-P	Compounding: Complex Nonsterile Compounding: Topical Dosage Forms	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
01/08/2018	0422-0000-17-332-H07-P	Compounding: Corrective Action and Preventative Action (CAPA) Plans for Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
01/08/2018	0422-0000-16-314-H04-P	Compounding: Sterile Compounding and USP Chapter <797>	Therapeutic Research Center	Home	General Pharmacy Topics	1.0 (0.1)	0.0	1.0	Application-based
12/21/2017	0422-0000-17-710-H01-P	Emerging Developments in Drug Therapy and Implementation into Patient Care: October 2017	Therapeutic Research Center	Home	Drug Therapy Related	1.0 (0.1)	0.0	1.0	Knowledge-based
12/21/2017	0422-0000-17-001-H01-P	Emerging Developments in Drug Therapy and Implementation into Patient Care: January 2017	Therapeutic Research Center	Home	Drug Therapy Related	1.0 (0.1)	0.0	1.0	Knowledge-based
12/21/2017	0422-0000-17-002-H01-P	Emerging Developments in Drug Therapy and Implementation into Patient Care: February 2017	Therapeutic Research Center	Home	Drug Therapy Related	1.0 (0.1)	0.0	1.0	Knowledge-based
12/21/2017	0422-0000-17-003-H01-P	Emerging Developments in Drug Therapy and Implementation into Patient Care: March 2017	Therapeutic Research Center	Home	Drug Therapy Related	1.0 (0.1)	0.0	1.0	Knowledge-based
12/21/2017	0422-0000-17-004-H01-P	Emerging Developments in Drug Therapy and Implementation into Patient Care: April 2017	Therapeutic Research Center	Home	Drug Therapy Related	1.0 (0.1)	0.0	1.0	Knowledge-based

This statement contains information provided to NABP from the Accreditation Council for Pharmacy Education (ACPE). The CPE provider is responsible for the accuracy of the CPE course data on the statement; however, NABP affirms that the participation information has been matched to the corresponding e-Profile data within its systems. Requests for changes to CPE course data must be directed to the ACPE-accredited provider that offered the course.
CPE documentation requirements are determined by each Board of Pharmacy; please check with your licensing board about these requirements.
CPE information has been made available to licensees' respective board(s) of pharmacy for use at the boards' discretion.

CPE Monitor Activity Transcript

Participant Name: Randy Bryan Smith — CPhT compounding lab
NABP e-Profile ID: 487505
CPE Activity Date Range: 10/03/2013 - 12/29/2017
Total CPE Hours Earned: 23.5

Recorded CPE activity for the period of 10/03/2013 to 12/29/2017. Please allow 60 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 60 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

Activity Date	ACPE UAN	Title	Provider	Format	Topic Designators	Contact Hours (CEU)	Live Hours	Home Hours	Activity Type
12/29/2017	0798-0000-16-090-H04-T	The Compounding Side of Hormone Therapy for Men and Women	PharmCon, Inc.	Home	General Pharmacy Topics	1.0 (0.1)	0.0	1.0	Knowledge-based
12/26/2017	0798-0000-15-122-H03-T	Compounded Medicines: New Laws, New Responsibilities, New Questions	PharmCon, Inc.	Home	Law	1.0 (0.1)	0.0	1.0	Knowledge-based
12/22/2017	0798-0000-16-137-H04-T	Decoding the Drug Quality and Security Act Pertinent to Sterile and Non-Sterile Compounding	PharmCon, Inc.	Home	General Pharmacy Topics	2.0 (0.2)	0.0	2.0	Knowledge-based
12/21/2017	0401-0000-16-504-H03-T	DSN Quick Credit: Applying law to pharmaceutical compounding	Drug Store News	Home	Law	0.25 (0.025)	0.0	0.25	Knowledge-based
12/21/2017	0798-0000-17-116-H04-T	USP 800 Compliance	PharmCon, Inc.	Home	General Pharmacy Topics	2.0 (0.2)	0.0	2.0	Knowledge-based
12/20/2017	0280-0000-16-082-H03-P	Sterile Compounding Update: Laws, Regulations & Standards	American Health Resources	Home	Law	1.25 (0.125)	0.0	1.25	Knowledge-based
10/03/2013	0201-0000-11-039-L01-T	Aseptic Technique Compounding	American College of Apothecaries, Inc.	Live	Drug Therapy Related	13.0 (1.3)	13.0	0.0	Application-based
10/03/2013	0201-0000-11-041-H01-T	Aseptic Technique Home Study	American College of Apothecaries, Inc.	Home	Drug Therapy Related	3.0 (0.3)	0.0	3.0	Knowledge-based

CPE Monitor Activity Transcript

Participant Name: Anthony Lee Westmoreland – RPh P.I.C.
NABP e-Profile ID: 390818
CPE Activity Date Range: 12/01/2017 - 01/01/2018
Total CPE Hours Earned: 15.0

Recorded CPE activity for the period of 12/01/2017 to 01/01/2018. Please allow 60 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 60 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

Activity Date	ACPE UAN	Title	Provider	Format	Topic Designators	Contact Hours (CEU)	Live Hours	Home Hours	Activity Type
12/26/2017	0422-0000-17-246-H05-P	Controlled Substances: Preventing Diversion and Promoting Patient Safety with Opioids	Therapeutic Research Center	Home	Patient Safety	2.0 (0.2)	0.0	2.0	Knowledge-based
12/26/2017	0422-0000-16-215-H01-P	The Balancing Act with Controlled Substances: Ensuring Access for Patients with Valid Prescriptions	Therapeutic Research Center	Home	Drug Therapy Related	2.0 (0.2)	0.0	2.0	Knowledge-based
12/25/2017	0422-0000-17-325-H07-P	Compounding: Understanding Requirements for Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/25/2017	0422-0000-17-236-H07-P	Compounding: Managing Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/25/2017	0422-0000-17-309-H04-P	USP-800 How to Handle Hazardous Meds in the Healthcare Setting	Therapeutic Research Center	Home	General Pharmacy Topics	1.0 (0.1)	0.0	1.0	Knowledge-based
12/25/2017	0422-0000-17-321-H07-P	Compounding: Sterile Compounding Aseptic Technique	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/25/2017	0422-0000-17-331-H07-P	Compounding: Complex Nonsterile Compounding: Topical Dosage Forms	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/25/2017	0422-0000-17-327-H07-P	Compounding: Maintaining a Controlled Environment for Sterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/25/2017	0422-0000-17-326-H07-P	Compounding: Complex Nonsterile Compounding Oral Dosage Forms	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/16/2017	0422-0000-17-311-H04-P	Nonsterile Compounding of Common Topical and Oral Liquid Preparations	Therapeutic Research Center	Home	General Pharmacy Topics	1.0 (0.1)	0.0	1.0	Application-based
12/16/2017	0422-0000-17-320-H07-P	Compounding: An Overview of Complex Nonsterile Compounding	Therapeutic Research Center	Home	Compounding	1.0 (0.1)	0.0	1.0	Knowledge-based
12/14/2017	0422-0000-16-307-H03-P	A Review of the Federal Pharmacy Law	Therapeutic Research Center	Home	Law	1.0 (0.1)	0.0	1.0	Application-based
12/06/2017	0422-0000-17-308-H03-P	A Review of DEA Requirements	Therapeutic Research Center	Home	Law	1.0 (0.1)	0.0	1.0	Knowledge-based

BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 2015 IBP 0053

IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF	)
	)
WESTMORELAND PHARMACY, INC.	)
LICENSE NUMBER 60005924A	)

PROPOSED SETTLEMENT AGREEMENT

The State of Indiana ("Petitioner"), by Amelia A. Hilliker, Deputy Attorney General, and Westmoreland Pharmacy, Inc. ("Respondent"), hereby execute this Settlement Agreement ("Agreement") to a disposition of the Administrative Complaint filed in this cause with the Indiana Board of Pharmacy ("Board"). This Agreement is subject to the review of the Board pursuant to Ind. Code § 25-1-9 *et seq*. and the Administrative Orders and Procedures Act, Ind. Code § 4-21.5-3 *et seq*.

STIPULATED FACTS

1. Respondent is a licensed closed door pharmacy in the State of Indiana having been issued license number 60005924A on or about December 20, 2005.

2. Respondent's address of record with the Indiana Professional Licensing Agency is 2125 State Street, New Albany, IN 47150.

3. On or around the beginning of 2014, Respondent began compounding drug products containing Domperidone.

4. Domperidone is approved for use in the United States in treating certain gastric disorders under special conditions which are outlined by the FDA.

5. Domperidone was removed from the market by the Food and Drug Administration ("FDA") in 1998 due to serious adverse effects, including irregular heartbeat, stopping of the heart, or sudden death.

6. Domperidone can only be obtained in the United States through the FDA's Expanded Access to Investigational Drugs Program ("IND"), and then only for patients 12 years of age and older with certain gastric disorders.

7. Prior to prescribing or dispensing Domperidone, a health care practitioner must submit an application to the FDA to become a Sponsor-Investigator as part of the IND and the IND must be in effect prior to the importation, interstate shipment, and administration of Domperidone.

8. To obtain Domperidone, the FDA has authorized only specific suppliers to provide the drug.

9. A health care practitioner who is a Sponsor-Investigator can obtain Domperidone for their patients through either direct import to their office for dispensing from one of the approved manufacturers, or by direct shipment to the patient by the approved pharmacy supplier.

10. Respondent compounded drug products containing Domperidone pursuant to a valid prescription for individual patients who did not have an IND in place.

11. Respondent conducted the activities described in Paragraph 10 above, without knowledge or belief that its actions were in violation of federal or state law. Respondent acted in reliance on materials widely distributed by a national trade association representing compounding pharmacies.

12. Respondent ceased compounding Domperidone after receiving a consumer complaint from the Office of the Indiana Attorney General in September of 2014 and conducting independent research on the drug.

STIPULATED CONCLUSIONS OF LAW

The parties further stipulate:

1. By the conduct described above, to wit violating the FDCA, 21 U.S.C. § 353a and 355, and 856 IAC 1-20-1(5), Respondent violated Ind. Code § 25-1-9-4(a)(3).

2. By Respondent's conduct in compounding drug products containing Domperidone for patients without a valid IND in place, Respondent violated Ind. Code § 25-1-9-4(a)(4)(B).

AGREED DISPOSITION

The parties agree to the following disposition:

1. The Board has jurisdiction over Respondent and the subject matter in this disciplinary action.

2. The parties execute this Agreement voluntarily.

3. Both parties voluntarily waive their rights to a public hearing on the Complaint and all other proceedings in this action to which either party may be entitled by law, including judicial review and appeal.

4. Petitioner agrees that the terms of this Agreement will resolve any and all pending claims or allegations relating to disciplinary action against the Respondent's Indiana pharmacy license.

5. Respondent agrees that they will receive the attached **LETTER OF REPRIMAND**, which will be included as a permanent part of Respondent's file located at the Indiana Professional Licensing Agency. (See Letter of Reprimand attached hereto as Exhibit "A".)

6. Respondent will ensure compounding staff undergo ten (10) hours of continuing education in the areas of FDA Regulations within one (1) year of the date of the Board's Final Order accepting this Agreement and provide proof of completion to the Board.

7. Within thirty (30) days of the date of the Board's Final Order accepting this Agreement, Respondent shall, pursuant to I.C. § 4-6-14-10 (b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order made payable to the State of Indiana, and submitted to the following address:

Indiana Office of the Attorney General
Attn: Teresa Henson
302 West Washington Street, 5th Floor
Indianapolis, IN 46204

8. Respondent has carefully read and examined this Agreement and fully understands its terms and that, subject to a final order issued by the Board, this Agreement is a final disposition of all matters and not subject to further review.

9. Respondent further understands that a violation of the Final Order accepting this Agreement, any non-compliance with the statutes or regulations regarding the practice of pharmacy, or any violation of the Settlement Agreement may result in the State requesting an emergency suspension of the Respondent's license, an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to I.C. § 25-1-9-4, any or all of which could lead to additional sanctions, up to and including a revocation of Respondent's license.

Westmoreland Pharmacy, Inc.

4-3-17
Date

Amelia A. Hilliker
Deputy Attorney General

4-4-2017
Date

March 28, 2017

Westmoreland Pharmacy, Inc.
2125 State Street
New Albany, IN 47150

Re: In the matter of the license of Westmoreland Pharmacy, LLC
Before the Indiana Board of Pharmacy

To Whom it May Concern:

This letter of reprimand issued in accordance with the Findings of Fact and Order issued by the Indiana Board of Pharmacy resolving the administrative complaint against your pharmacy license filed by the Office of the Attorney General, Division of Consumer Protection on October 14, 2015.

The purpose of this reprimand is to stress the important responsibility that you have by reason of possession of a pharmacy license in the State of Indiana.

The Settlement Agreement, Findings of Fact, and Final Order are attached and incorporated herein as part of this reprimand.

It is your responsibility to conduct your practice as a pharmacy in accordance with the statutes, regulations, and standards of the profession.

Sincerely,

INDIANA BOARD OF PHARMACY

By: _____
Steve Anderson, R.Ph., President

EXHIBIT "A"

BEFORE THE INDIANA BOARD OF PHARMACY
CAUSE NO: 2015 IBP 0053

IN THE MATTER OF THE INDIANA PHARMACY LICENSE OF

WESTMORELAND PHARMACY, INC.
LICENSE NUMBER 60005924A

FINAL ORDER ACCEPTING PROPOSED SETTLEMENT AGREEMENT

The State of Indiana ("Petitioner"), by Amelia A. Hilliker, and Westmoreland Pharmacy, Inc. ("Respondent"), signed a "Settlement Agreement" ("Agreement"), filed on April 4, 2017, which purports to resolve all issues involved in the action by the Petitioner and the Indiana Board of Pharmacy ("Board") regarding the Respondent's license, and which Agreement has been submitted to the Board for approval.

The Board after reviewing the Agreement at the April 10, 2017, meeting held in Room W064 of the Indiana Government Center South, 402 West Washington Street, Indianapolis, Indiana 46204, now finds it has been entered into fairly and without fraud, duress, or undue influence, and is fair and equitable between the parties. The Board hereby incorporates the Agreement which is attached hereto and incorporated herein as **Exhibit A**, into this Final Order.

WHEREFORE, the Board hereby accepts and approves the Findings of Facts, Conclusions of Law, and Agreed Disposition presented by the parties and issues this Final Order, by a vote of 6-0:

1. Respondent's Indiana pharmacy license shall be issued **LETTER OF REPRIMAND**, which will be included as a permanent part of Respondent's file located at the Indiana Professional Licensing Agency.

2. Respondent will ensure compounding staff undergo ten (10) hours of continuing education in the areas of FDA Regulations within one (1) year of the date of the Board's Final Order accepting this Agreement and provide proof of completion to the Board.

3. Within thirty (30) days of the date of this Order, Respondent shall, pursuant to I.C. § 4-6-14-10(b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order made payable to the State of Indiana and submitted to the following address:

Indiana Office of the Attorney General
Attn: Teresa Henson
302 W. Washington Street, 5th Floor
Indianapolis, IN 46204

4. A violation of this Final Order, any non-compliance with the statutes or regulations regarding the practice of pharmacy may result in an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to Ind. Code § 25-1-9-4, and or all of which could lead to additional sanctions.

SO ORDERED, this 10th day of May, 2017.

INDIANA BOARD OF PHARMACY

Maureen Bennett
for Steve Anderson, R. Ph, Vice President
Indiana Board of Pharmacy

CERTIFICATE OF SERVICE

I certify that a copy of the "Final Order Accepting Proposed Settlement Agreement" has been duly served upon:

Westmoreland Pharmacy, Inc.
c/o Anthony Westmoreland
1945 State Street
New Albany, IN 47150
Service by US Mail

Amelia A. Hilliker
Deputy Attorney General
302 West Washington Street, 5th Floor
Indianapolis, IN 46204
Amelia.Hilliker@atg.in.gov
Service by E-Mail

5-10-17
Date

Donna Moran
Donna Moran, Litigation Specialist

Indiana Board of Pharmacy
Indiana Government Center South
302 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: 317-234-2067
Email: pla4@pla.in.gov

Explanation of Service Methods
Personal Service: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual's electronic mail address.

Professional Licensing Agency
402 West Washington Street
Room W072
Indianapolis, IN 46204

Eric J. Holcomb
Governor of Indiana
Deborah J. Frye
PLA Executive Director

May 9, 2017

Westmoreland Pharmacy, Inc.
2125 State Street
New Albany, IN 47150

Re: In the matter of the license of Westmoreland Pharmacy, LLC
Before the Indiana Board of Pharmacy

To Whom it May Concern:

This letter of reprimand issued in accordance with the Findings of Fact and Order issued by the Indiana Board of Pharmacy resolving the administrative complaint against your pharmacy license filed by the Office of the Attorney General, Division of Consumer Protection on October 14, 2015.

The purpose of this reprimand is to stress the important responsibility that you have by reason of possession of a pharmacy license in the State of Indiana.

The Settlement Agreement, Findings of Fact, and Final Order are attached and incorporated herein as part of this reprimand.

It is your responsibility to conduct your practice as a pharmacy in accordance with the statutes, regulations, and standards of the profession.

Sincerely,

INDIANA BOARD OF PHARMACY

By: Maureen Bennett
for Steve Anderson, R.Ph., President

EXHIBIT "A"

Mailed to IDBOP 2/6/18

WESTMORELAND
PHARMACY + COMPOUNDING

State of Illinois

Board of Pharmacy

February 6, 2018

RE: No. 2017-01360

This is the written answer to the above-referenced complaint again our pharmacy, Westmoreland Pharmacy at 1945 State St, New Albany IN 47150.

Count 1, Paragraphs 1-9

We admit this allegation.

Count 2, Paragraph 10

We admit this allegation.

Please contact me directly at 502-298-9085 if there are any further questions.Sincerely,

Anthony L. Westmoreland RPh

PIC, Westmoreland Pharmacy

Illinois License 054.016721,320.009596

INDIVIDUAL ACKNOWLEDGMENT

State/Commonwealth of Indiana
County of Floyd } ss.

On this the 6th (Day) day of February (Month), 2018 (Year), before me, Laura Wheatley (Name of Notary Public), the undersigned Notary Public, personally appeared Anthony L. Westmoreland (Name(s) of Signer(s))

☐ personally known to me – **OR** –

☑ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that he/she/they executed the same for the purposes therein stated.

WITNESS my hand and official seal.

LAURA WHEATLEY
Notary Public- Seal
State of Indiana
My Commission Expires Aug 9, 2021

Laura Wheatley
Signature of Notary Public

Place Notary Seal/Stamp Above

Any Other Required Information (Printed Name of Notary, Expiration Date, etc.)

INFORMATION IN AREAS 1-4 REQUIRED IN ARIZONA. OPTIONAL IN OTHER STATES.

Description of Any Attached Document

1 Title or Type of Document: St. of Illinois Board of Pharmacy.
2 Document Date: February 6, 2018 3 Number of Pages: 1
4 Signer(s) Other Than Named Above: N/A.

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION, DIVISION OF PROFESSIONAL REGULATION of the State of Illinois, Complainant, v. WESTMORELAND PHARMACY INC, License No. 054.016721, 320.009596, Respondent.	)	No. 2017-01360

NOTICE OF PRELIMINARY HEARING

TO: WESTMORELAND PHARMACY INC
ANTHONY WESTMORELAND
1945 STATE ST
NEW ALBANY, IN 47150-4919

PLEASE TAKE NOTICE that on March 19th, **2018, at 1:00 p.m.**, you are directed to appear before the Administrative Law Judge of the Division of Professional Regulation of the Department of Financial and Professional Regulation of the State of Illinois, located at 100 West Randolph Street, Suite 9-300, Chicago Illinois 60601, at which time a hearing date will be set. You are requested to then and there present any and all routine motions you may wish to have heard regarding the charges contained in the attached Complaint. Any motions presented on the above date should be served on the Adjudicative Services Unit of the Department of Financial and Professional Regulation, Division of Professional Regulation, 100 West Randolph Street, Suite 9-300, Chicago Illinois 60601 at least three (3) business days in advance of the scheduled hearing.

Your appearance on the scheduled date and time is mandatory and your failure to so appear may result in the selection of a hearing date in your absence, unless a continuance has been secured in advance. Your appearance may be made personally or through counsel.

It is required that you file a written ANSWER UNDER OATH AND UNDER PENALTY OF PERJURY to the attached Complaint under oath with the Department of Professional Regulation within (20) days of the date this Notice was mailed. The answer should address each numbered paragraph of the Complaint. The answer shall be signed under oath and your signature must be verified by a notary public who affixes the notary seal to the document. For each paragraph, the Answer should either:

a) admit the allegation in the paragraph
b) deny the allegation in the paragraph, or
c) state under oath that you have insufficient information with which to admit or deny the allegation in the paragraph

PLEASE BE ADVISED that the failure to file a verified Answer may subject you to being held in default. If you are held in default, the Board will assume the allegation to be true and will issue a recommendation based upon those facts without a hearing being held. These proceedings are held pursuant to the jurisdiction granted to the Department to investigate complaints and to bring this action pursuant to 20 Ill. Comp. Stat. 2105-15(a)(5) and 225 Ill. Comp. Stat. 60/36 (2006 as amended).

RULES OF PRACTICE IN ADMINISTRATIVE HEARINGS IN THE DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION AND BEFORE COMMITTEES OR BOARDS OF SAID DEPARTMENT AS WELL AS PRACTICE ACTS AND RULES MAY BE FOUND AT http://www.idfpr.com/dpr/default.asp.

PLEASE BE ADVISED THAT YOU WILL HAVE TO SHOW A STATE ISSUED PHOTO IDENTIFICATION AND GO THROUGH A METAL DETECTOR IN ORDER TO GAIN ACCESS TO THE BUILDING.

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION OF THE STATE OF ILLINOIS, DIVISION OF PROFESSIONAL REGULATION

By: _____
Frank Lamas
Chief of Health-Related Prosecutions

Brandon Thom/ck
Attorney, Health Related Prosecutions
IDFPR Division of Professional Regulation
100 W. Randolph St., Suite 9-300
Chicago, IL 60601
(312) 814-1693
Brandon.Thom@illinois.gov
Enf. ID: 2017-01360
Respondents: WESTMORELAND PHARMACY, 054.016721, 320.009596

STATE OF ILLINOIS)
)
COUNTY OF COOK)

SS: 2017-01360

UNDER PENALTY OF PERJURY, as provided by law, Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that I caused the attached Notice Preliminary Hearing and Complaint to be deposited in the United States mailbox located at 100 West Randolph Street, Chicago, Illinois 60601, and by mailing same by certified mail at 100 West Randolph Street, Chicago, Illinois, 60601, with proper postage prepaid to the parties at the addresses listed above, prior to 5:00 p.m. on the 22 day of January, 2018.

Crystal Rivera
AFFIANT

Cert. Mail No: 7017 1070 0000 9339 4494

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION, DIVISION OF PROFESSIONAL REGULATION of the State of Illinois, Complainant, v. WESTMORELAND PHARMACY INC, License No. 054.016721, 320.009596, Respondent.	)	No. 2017-01360

COMPLAINT

NOW COMES THE DIVISION OF PROFESSIONAL REGULATION of the DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION of the State of Illinois ("Department"), by its Chief of Health-Related Prosecutions, Frank Lamas, and as its Complaint against WESTMORELAND PHARMACY, INC, Respondent, complains as follows:

COUNT I
UNLICENSED PRACTICE

1. The Department has the legal power and duty to investigate the conduct of licensees and take disciplinary action in administration and enforcement of the Illinois Pharmacy Practice Act, 225 ILCS 85/1 et seq., and the Rules adopted by the Department in furtherance of the Act, 68 Ill. Admin. Code § 1330.10 et seq.
2. WESTMORELAND PHARMACY, INC (hereinafter "Respondent Pharmacy") is the holder of a Pharmacy license in the State of Illinois, License Number 054.016721.
3. Respondent Pharmacy is the holder of a Controlled Substance License, License Number 320.009596, in the State of Illinois issued by the Department.
4. On or about March 31, 2016, Respondent's pharmacy license expired.
5. On or about March 31, 2016, Respondent's Controlled Substance license expired.
6. Respondent Pharmacy practiced with a non-renewed pharmacy license from April 1, 2016 to September 4, 2016.

7. Respondent Pharmacy practiced with a non-renewed Controlled Substance license from April 1, 2016 to September 4, 2016.
8. Between April 1, 2016, and September 4, 2016, Respondent Pharmacy dispensed prescriptions to Illinois Residents.
9. Respondent Pharmacy has engaged in the unlicensed practice of Pharmacy and unlicensed dispensing of controlled substances in the State of Illinois.
10. The foregoing acts or omissions are in violation of 225 ILCS 85/5.5(a), 225 ILCS 85/12(f), 225 ILCS 85/30(a)(2), 225 ILCS 85/30(a)(4), 225 ILCS 85/30(a)(7), 720 ILCS 570/302, 720 ILCS 570/304(a)(5), 702 ILCS 570/312, 68 Ill. Admin. Code 1330.30, and 68 Ill. Admin. Code 1330.40.
11. The foregoing acts, omissions, and violations are grounds for discipline pursuant to 225 ILCS 85/30 (a)(2), 225 ILCS 85/30 (a)(4), 225 ILCS 85/30 (a)(7), and 720 ILCS 570/304(a)(5).

WHEREFORE, based on the foregoing allegations, the Department of Financial and Professional Regulation of the State of Illinois, Division of Professional Regulation, by Frank Lamas, its Chief of Health-Related Prosecutions, prays that the Pharmacy license of WESTMORELAND PHARMACY, INC, License No. 054.016721, be suspended, revoked, or otherwise disciplined and that Respondent be fined an amount not to exceed $10,000 per violation in accordance with the Illinois Pharmacy Practice Act; and that the Illinois Controlled Substance License of WESTMORELAND PHARMACY, INC, License No. 320.009596, be suspended, revoked, or otherwise disciplined and that Respondent be fined an amount not to exceed $10,000 per violation in accordance with the Illinois Controlled Substances Act.

COUNT II
UNPROFESSIONAL CONDUCT

1-9. The Department repeats and realleges paragraphs 1 through 9 of Count I as paragraphs 1 through 9 of this Count as if the same were fully stated herein.
10. Respondent Non-Resident Pharmacy engaged in unprofessional conduct by dispensing medications to Illinois Residents when it had not renewed its Illinois pharmacy license.

11. The foregoing acts or omissions are in violation of 225 ILCS 85/5.5(a), 225 ILCS 85/30 (a)(2), 225 ILCS 85/30 (a)(4), 225 ILCS 85/30 (a)(7), and 68 Ill. Admin. Code 1330.30.
12. The foregoing acts, omissions, and violations are grounds for discipline pursuant to 225 ILCS 85/5.5(a), 225 ILCS 85/30 (a)(2), 225 ILCS 85/30 (a)(4), and 225 ILCS 85/30 (a)(7).

WHEREFORE, based on the foregoing allegations, the Department of Financial and Professional Regulation of the State of Illinois, Division of Professional Regulation, by Frank Lamas, its Chief of Health-Related Prosecutions, prays that the Pharmacy license of WESTMORELAND PHARMACY, INC, License No. 054.016721, be suspended, revoked, or otherwise disciplined and that Respondent be fined an amount not to exceed $10,000 per violation in accordance with the Illinois Pharmacy Practice Act.

DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION of the State of Illinois
DIVISION OF PROFESSIONAL REGULATION

By: 
Frank Lamas
Chief of Health-Related Prosecutions

Brandon Thom
Attorney, Health Related Prosecutions
IDFPR Division of Professional Regulation
100 W. Randolph St., Suite 9-300
Chicago, IL 60601
(312) 814-1693
Brandon.Thom@illinois.gov
Enf. ID: 2017-01360
Respondents: WESTMORELAND PHARMACY, 054.016721, 320.009596

10

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE OUTSOURCING FACILITY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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 Outsourcing Facility
☐ Ownership Change (Provide current license number if making changes:) OUT_____
☐ 503a OR ☐ 503b Apply as retail pharmacy only.

Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Publicly Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1-3 & 4
☒ Non Publicly Traded Corporation – Pages 1-3 & 5
☐ Partnership - Pages 1-3 & 6
☐ Sole Owner – Pages 1-3 & 7

GENERAL INFORMATION to be completed by all types of ownership

Facility Name: Central Admixture Pharmacy Services, Inc.

Physical Address: 6580 Snowdrift Road #100

City: Allentown State: PA Zip Code: 18106

Telephone: 610-395-5170 Fax: 610-395-5178

Toll Free Number: 855-275-2270 (Required per NAC 639.708)

E-mail: Greg.Smith@CAPSpharmacy Website: www.capspharmacy.com

Supervising Pharmacist: Greg Smith Nevada License #: 198444

SERVICES PROVIDED

Yes/No

☒ ☐ Parenteral
☒ ☐ Sterile Compounding
☐ ☐ Non Sterile Compounding
☐ ☒ Mail Service Sterile Compounding
☐ ☒ Other Services: _____

All boxes must be checked for the application to be complete

An appearance will be required at a board meeting before the license will be issued.

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR OUT-OF STATE OUTSOURCING FACILITY **Page 2**

FEI Number (From FDA application): 3009590582

Please provide the name of the facility as registered with the FDA and the registration number:
Central Admixture Pharmacy Services, Inc. #3009590582

Please provide a list of all DBA's used by outsourcing facility. A separate sheet is acceptable.

NA

Please provide the name and Nevada license number of the supervising pharmacist:
Name: Greg Smith Nevada License Number: 19844

A Nevada business license is not required, however if the Outsourcing Facility has a Nevada business license please provide the number: None

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, cite fine or proceeding relating to the pharmaceutical industry? Yes ☒ No ☐

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 question 1 through 5 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.

APPLICATION FOR OUT-OF STATE OUTSOURCING FACILITY - Page 3

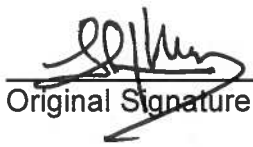
I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized Outsourcing Facility may be grounds for the revocation of this permit.

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. The facility must be registered with the FDA as an outsourcing facility (503B) to obtain an outsourcing facility from the Board of Pharmacy.

Federal and State law require a licensed pharmacist to supervise the compounding taking place in a registered outsourcing facility. This supervising pharmacist must be licensed by the Nevada Board of Pharmacy.

Does your outsourcing facility wholesale compounded medication for resale? Yes ☐ No ☒

The Law prohibits the resale of compounded medication. By signing this application you are attesting that your medications will be labeled with the statement "Not for Resale" and that the outsourcing facilities products will not be resold.



Original Signature of Person Authorized to Submit Application, no copies or stamps

Tom Wilverding

Print Name of Authorized Person

3/18/2019

Date

APPLICATION FOR OUT-OF-STATE OUTSOURCING FACILITY **Page 5**

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: B. Braun of America Inc.

Address: 824 12th Avenue

City: Bethlehem State: PA Zip: 18108

Telephone: 919-806-4448 Fax: _____

Contact Person: Tom Wilverding

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) B. Braun owns 100% of the shares of Central Admixture Pharmacy Services, Inc.
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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 corporation's stock register evidencing the above information

Include with the application for a non publicly traded corporation

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors

CENTRAL ADMIXTURE PHARMACY SERVICES, INC.
DISCIPLINARY ACTIONS

11/23/1993 - Florida Department of Business and Professional Regulation
Complaint alleged prescriptions were being improperly dispensed. According to the Florida Administrative Code, the pharmacist must be directly and immediately available to the patient when dispensing prescriptions. CAPS dispenses to a third party hospital when dispensing prescriptions. CAPS received a rule change from the Florida legislature, which provided for a license to fit the description of CAPS' operation and provision of modern, safe and effective pharmacy admixture services to the medical industry in the state of Florida. A Stipulation was entered into on October 4, 1996, as "disposition of the Administrative Complaints." The Stipulation called for an administrative fine of $2,000 and a representative of CAPS to enroll in and complete a 12 hour continuing education course.

3/1/1995 – Illinois Department of Professional Regulation
Complaint alleged CAPS was providing a majority of its sales to home health care or hospital patients while licensed as a Division I retail pharmacy and CAPS was not compliant with the Illinois Pharmacy Practice Act of 1987 85/18 relating to record keeping. CAPS immediately corrected the record keeping violation and applied for a Division II Pharmacy License and a Wholesale Distributor License. The Department of Professional Regulations and CAPS entered into a Stipulation and Recommendation For Settlement in May of 1996. The Stipulation noted the Division I license would be replaced by a Division II which would be issued by the state of Illinois. There was also a minor reprimand against the pharmacist in charge and a minor fine paid.

8/3/1994 - Michigan Department of Commerce, Bureau of Occupational and Professional Regulation
Order requiring CAPS to cease and desist from acting as a manufacturer in the State of Michigan. Prior to any need for an administrative hearing, CAPS filed an application for a wholesaler license with the state of Michigan and registered with the Federal Food and Drug Administration (FDA). CAPS registration as a wholesaler satisfied the state requirements.

9/16/2005 - Maryland Board of Pharmacy
Order requiring CAPS to temporarily cease operations during an investigation of certain issues related to aseptic sterile compounding. CAPS implemented corrective action plans to address its aseptic sterile compounding procedures. On January 31, 2006, CAPS adequately implemented a sufficient corrective action plan and the Maryland facility reopened.

CENTRAL ADMIXTURE PHARMACY SERVICES, INC.
CITATIONS

Central Admixture Pharmacy Services, Inc.
160 W. Forrest Avenue
Englewood, NJ 07631

8/16/2016 (Current) -New Jersey Board of Pharmacy

Failed to submit Central Prescription Handling Agreements with New York hospital customers to the Board. Cooperation Agreements (as agreed upon by the NJ DAG, as an alternative to the Central Prescription Handling Agreement) have been submitted to the Board. Currently awaiting confirmation from Board of resolution of citation.

7/15/14 - New Jersey Board of Pharmacy
$2,000 – Fined for exceeding the technician to pharmacist ratio of 2:1. $2,000 fine was paid and corrective action letter was submitted to the Board. Matter closed.
$5,000 – Fined for failure to submit Central Prescription Handling Agreements with New Jersey hospital customers to the Board. $5,000 fine was paid and Central Prescription Handling Agreements were submitted to the Board. Matter closed.

2/10/06 – New Jersey Board of Pharmacy
$500.00 - Fined for no sink in anteroom. $500.00 fine was paid and sink installed. Matter closed.
$500.00 – Fined for no Eyewash Station. $500.00 fine paid and installed eye wash station. Matter closed.
$500.00 - Fined for violation of the Tech/Pharmacist Ratio. $500.00 fine paid. Matter closed.

Central Admixture Pharmacy Services, Inc.
9730 Martin Luther King Jr. Highway, Units C & D
Lanham, MD 20706

12/19/2011 Maryland Board of Pharmacy
$2,000.00 - Fine for inspection finding of un-registered Technicians. $2,000.00 fine paid. Matter closed.

Central Admixture Pharmacy Services, Inc.
10370 Slusher Drive, Unit 6
Santa Fe Springs, CA 90670

2/27/2015 – California Board of Pharmacy

Pharmacy License citation: $2,500 – Fined for violation of Tech/Pharmacist Ratio. $2,500 fine paid. Matter closed.
Sterile Compounding License citation: violation of Tech/Pharmacist Ratio. No fine. Matter closed.

9/22/2008 – California Board of Pharmacy
$750.00 - Fined for violation of Tech/Pharmacist Ratio. $750.00 fine paid. Matter closed.

Central Admixture Pharmacy Services, Inc.
1433 Sams, Suite A & C
Harahan, LA 70123

12/07/11 - Louisiana Board of Wholesale Distributors
$750.00 – Fined for failure to secure front door of pharmacy allowing for unauthorized entry and access from outside. $750.00 fine paid and front door secured. Matter closed.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "CENTRAL ADMIXTURE PHARMACY SERVICES, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE EIGHTEENTH DAY OF JANUARY, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "CENTRAL ADMIXTURE PHARMACY SERVICES, INC." WAS INCORPORATED ON THE FIFTH DAY OF DECEMBER, A.D. 1990.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

2248466 8300

SR# 20190369771

Authentication: 202107924

Date: 01-18-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

10/26/2018

TO ALL WHOM THESE PRESENTS SHALL COME, GREETING:

I DO HEREBY CERTIFY THAT,

CENTRAL ADMIXTURE PHARMACY SERVICES, INC.

is duly registered to do business under the laws of the Commonwealth of Pennsylvania and remains a registered Foreign Business Corporation so far as the records of this office show, as of the date herein.

I DO FURTHER CERTIFY THAT this Certificate of Registration shall not imply that all fees, taxes and penalties owed to the Commonwealth of Pennsylvania are paid.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Seal of the Secretary's Office to be affixed, the day and year above written

Robert Torres

Acting Secretary of the Commonwealth

Certification Number: TSC181026171586-1

Verify this certificate online at http://www.corporations.pa.gov/orders/verify

NEVADA STATE BOARD OF PHARMACY

(Licensee mailing address for window envelope)

THIS STUB IS YOUR RECEIPT

Date: 03/28/2018
Amount: 330.00
License #: 19844

GREGORY DOUGLAS SMITH
1420 NEWLINS RD W
EASTON, PA 18040

(ID Card)

Trim ID Card to fit your wallet

NEVADA BOARD OF PHARMACY

License #
19844
Active

PHARMACIST

Expires:10/31/2019

GREGORY DOUGLAS SMITH
1420 NEWLINS RD W
EASTON, PA 18040

IDENTIFICATION ONLY
DOES NOT MEET POSTING REQUIREMENTS

STATE OF NEVADA
STATE BOARD OF PHARMACY
PHARMACIST

THE UNDER-NOTED HAVING PAID STATUTORY FEE IS HEREBY LICENCED

License Type: PHARMACIST

License #: 19844

Expires: 10/31/2019
STATUS: Active

1st License Date: March 28, 2018

GREGORY DOUGLAS SMITH
1420 NEWLINS RD W
EASTON, PA 18040

NONTRANSFERABLE
POST THIS LICENSE PROMINENTLY IN A CONSPICUOUS PLACE

Central Admixture Pharmacy Services, Inc. (CAPS) - OFFICERS

Name and Title	Business Address and Phone:
Thomas J. Wilverding President	2530 Meridian Parkway, Suite 200 Durham, NC 27713 919-806-4448 tom.wilverding@capspharmacy.com
Michael A. Koch SR. Vice President, Professional Services	16800 Aston Street, Suite 150 Irvine, CA 92606 949-660-2701 mike.koch@capspharmacy.com
Bruce Heugel Treasurer (Chief Financial Officer)	824 Twelfth Avenue Bethlehem, PA 18018 610-997-4050 bruce.heugel@bbraunusa.com
Cathy L. Codrea Secretary	824 Twelfth Avenue Bethlehem, PA 18018 610-997-4581 cathy.codrea@bbraunusa.com

Central Admixture Pharmacy Services, Inc. 16800 Aston Street, Suite 150 Irvine, CA 92606 *State of Incorporation:* Delaware	C Corporation 33-0439686
B. Braun of America Inc. 824 12th Avenue Bethlehem, PA 18108 *State of Incorporation:* Pennsylvania	Owns CAPS stock 100% 23-2115335

Certificate of Licensure

Certificate No. 8000002947
(A certificate starting with a number 4, 5 or 6 does not permit the posession or sale of controlled substances or prescription drugs.)

Category:

Wholesaler/Distributor

Drug & Device Registration
132 Kline Plaza
Suite A
Harrisburg, PA 17104
(717) 787-4779

CENTRAL ADMIXTURE PHARMACY SERVICES, INC.
6580 SNOWDRIFT ROAD, SUITE 100
ALLENTOWN, PA 18106

The above business is registered in the required category to conduct and maintain a facility in accordance with the provisions of the Wholesale Prescription Drug License Act, Act #145, approved December 14, 1992.

Issuance Date: May 07, 2018
Expiration Date: The Last Day of May, 2019

Nancy J. Lescavage
Deputy Secretary for Quality Assurance

pennsylvania
DEPARTMENT OF HEALTH

Rachel L. Levine, MD
Secretary of Health

NOTE: THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE ON THE PREMISES.

Certificate of Registration

Certificate No. 1000003945
(A certificate starting with a number 4, 5 or 6 does not permit the posession or sale of controlled substances or prescription drugs.)

Category:

Manufacturer (Prescription)

Drug & Device Registration
132 Kline Plaza
Suite A
Harrisburg, PA 17104
(717) 787-4779

CENTRAL ADMIXTURE PHARMACY SERVICES, INC.
6580 SNOWDRIFT ROAD, SUITE 100
ALLENTOWN, PA 18106

The above business is registered in the required category to conduct and maintain a facility in accordance with the provisions of the Controlled Substance, Drug, Device and Cosmetic Act #64, approved September 9, 1972.

Issuance Date: May 07, 2018
Expiration Date: The Last Day of May, 2019

Nancy J. Lescavage
Deputy Secretary for Quality Assurance

pennsylvania
DEPARTMENT OF HEALTH

Rachel L. Levine, MD
Secretary of Health

NOTE: THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE ON THE PREMISES.

11

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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 Wholesaler ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: WH_____)

☒ Publicly Traded Corporation – Page 1,2,3,4 ☐ Partnership - Page 1,2,3,6a,6b
☐ Non Publicly Traded Corporation – Page 1,2,3,5a,5b ☐ Sole Owner – Page 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: US ECOLOGY NEVADA

Physical Address: Hwy 95, 11 MILES S. OF BEATTY

Mailing Address: Po Box 578

City: BEATTY State: NV Zip Code: 89003

Telephone: 775.553.2203 Fax: 775.553.2125

Toll Free Number: 1.800.239.3943

E-mail: daniel.church@usecology.com Website: www.usecology.com

Facility Manager: DANIEL CHURCH

Professional qualifications and experience of facility manager: MR CHURCH HAS 12+ YEARS EXPERIENCE WORKING AT AND MANAGING A RCRA TSDF.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled be firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☒ Controlled Substances (include copy of DEA) SEE ATTACHED
☐ Other: _____

APPLICATION FOR NEVADA WHOLESALER LICENSE

This page must be submitted for all types of ownership.

Is your company VAWD certified by NABP? Yes ☐ No ☒
(If yes, provide a copy of the certificate.)

Licensed as a Manufacturer by the FDA? Yes ☐ No ☒
(If yes, provide a copy of the FDA registration)

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 ☒

List the top 4 suppliers your company has been associated with in regards to pharmaceutical products that were sold, dispensed or distributed within the last year.

1) NOT APPLICABLE
Name Address
Business

2)
Name Address
Business

3)
Name Address
Business

4)
Name Address
Business

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest) or partners with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

APPLICATION FOR NEVADA WHOLESALER LICENSE

This page must be submitted for all types of ownership.

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest) or partners with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, 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 question 1 through 5 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. SEE ATTACHED EXPLANATION FOR #5.

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 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

DANIEL CHURCH
Print Name of Authorized Person

4/11/19
Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR NEVADA WHOLESALER LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: DELAWARE

Parent Company if any: US ECOLOGY INC.

Corporation Name: US ECOLOGY NEVADA INC.

Mailing Address: 101 S. CAPITOL BLVD, STE 1000

City: BOISE State: ID Zip: 83702

Telephone: 800.590.5220 Fax: 208.331.7900

Contact Person: JEFF FEELER

Ownership Information – Complete Section 1 or 2

Do not use N/A in this section – Section 1 or 2 must be completed.

Section 1: List the corporations four largest shareholders:
(Name and percentage of ownership)

1. _____ %: _____

2. _____ %: _____

3. _____ %: _____

4. _____ %: _____

Section 2: If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

*Date of Incorporation: 5/10/2004

*Registration number issued: 3800885

*Stock Exchange: NASDAQ

Include with the application for a publicly traded corporation

List of officers and directors. SEE ATTACHED

Certificate of Corporate status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months. SEE ATTACHED

Copy of DEA, Page 1

An application to DEA is in progress. DEA requires that a State License Number be provided before accepting the completed DEA Registration Application. US Ecology will coordinate with the Nevada State BOP to address the overlapping requirements.

Answer to Question 5, Page 3:

Location: 1923 Frederick St, Detroit, MI 48211

Nature: In June 2014, US Ecology purchased the Environmental Quality Company (EQ) which included a facility called EQ Detroit (EQD). EQD had a DEA Reverse Distributor License in operation since 2009 and conducted pickups of waste pharmaceuticals from retail stores. Ass this business grew from 2009 to 2012, DEA Detroit Office (2012 inspection) determined that EQD's record keeping did not meet 21 CFR regulatory requirements. Registration No. RE0379924.

Disposition: An August 2016 inspection by the DEA Detroit office showed the site program, procedures and controls were not sufficient for supporting a nationwide collection program for regulated substance to comply with the October 2014 regulatory changes to DEA requirements. DEA Detroit office asked EQD to voluntarily surrender their license until the program was changed to implement the new policies and procedures, where they could reapply for their distributor license and resume operations.

List of Officers and Directors, Page 4

Jeff Feeler, President/CEO and Director

Eric Gerrat, Vice President and Treasurer

Simon Bell, Vice President of Operations

Wayne R. Ipsen, Vice President, General Counsel and Secretary

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "US ECOLOGY NEVADA, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE ELEVENTH DAY OF APRIL, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

3800885 8300

SR# 20192746695

Authentication: 202622492

Date: 04-11-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

12

12A

4/3

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☑ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: All time Health Care

Physical Address: 4660 S. Eastern Ave Ste # 100 LV NV 89119

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

Mailing Address: 4660 S. Eastern Ave Ste # 100

City: LV State: NV Zip Code: 89119

Telephone: 702-480-5617 Fax: _____

E-mail: alltimehealthcare@gmail.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5PM Tue: 9am to 5PM Wed: 9am to 5PM Thu: 9am to 5PM

Fri: 9am to 5PM Sat: 9am to 5PM Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Angelica Gutierrez

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: Incontinence & disposable supplies

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: _____ Telephone: _____

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

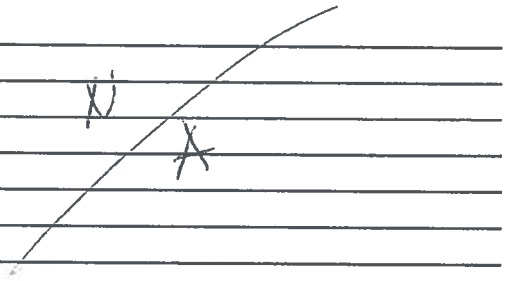
Medicare	In process	
Medicaid	In process	

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 ☑

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☑

3) Are any of the owners health professionals? If yes, please check the box and list name.

- ☐ Practitioner — Name:
- ☐ Advanced Practitioner of Nursing — Name:
- ☐ Physician's Assistant — Name:
- ☐ Physical Therapist — Name:
- ☐ Occupational Therapist — Name:
- ☐ Registered Nurse — Name:
- ☐ Respiratory Therapist — Name:



Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 questions 1 through 5 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 or 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Dailin Carmenate Arias — 3/27/19

Print Name of Authorized Person — Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Dailin Carmenate Rivas

Business Name: all time Health care

Current Business Address: 4660 S Eastern Ave ste# 100

City: LV State: NV Zip: 89119

Telephone: 702-480-5617 Fax: _____

SOLE OWNER

Include with the application for a sole owner

Complete personal history record Must be original signature(s), no copies or stamps. Download the form from the website. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

ALL TIME HEALTH CARE LLC

Nevada Business Identification # NV20191240010

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 27, 2019

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law cannot be waived.

SECRETARY OF STATE

STATE OF NEVADA

LIMITED LIABILITY COMPANY CHARTER

I, Barbara K. Cegavske, the Nevada Secretary of State, do hereby certify that **ALL TIME HEALTH CARE LLC** did on March 27, 2019, file in this office the Articles of Organization for a Limited Liability Company, that said Articles of Organization is now on file and of record in the office of the Nevada Secretary of State, and further, that said Articles contain all the provisions required by the laws governing Limited Liability Companies in the State of Nevada.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 27, 2019.

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

Certified By: Electronic Filing
Certificate Number: C20190327-1751

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 3/22/19

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 Durable Medical Equipment

Nature of MDEG

Alltime Health care 4660 S. Eastern ave ste 100 LV NV 89119

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Gutierrez — Last Name
Angelica — First Name
Middle Name

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

Spring Rain Rd — Present Residence Address-Street or RFD — Las Vegas — City — NV 89142 — State/Zip

4660 S. Eastern Ave. Suite 100 — Present Business Address — Dates 4/1/19 — Las Vegas — City — NV 89119 — State/Zip

Administrator — Present Position with the MDEG — Dates 4/1/19 - Present

Phone: [redacted] Fax: _____

Email address: Alltimehealthcare19@gmail.com

[redacted] — Date of Birth
Las Vegas, USA, NV — Place of Birth (City, County, State)

22 — Age
[redacted] — Social Security Number
F — Sex

Brown — Color of Eyes
Brown — Color of Hair
120 — Weight
5'0 — Height

Scars, tattoos or distinguishing marks and/or characteristics _____

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.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Jan 2017-2019	Touro Health Center 874 American Pacific Dr NV. 89104	(3840)
Title	Description of Duties	Name of Supervisor
Front office receptionist		Tina Galendo
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
September 2015- Jan2017	Cima Medical Center 3115 S. Eastern Ave. LV NV 89169	3840
Title	Description of Duties	Name of Supervisor
Front office receptionist		Patricia Webb.
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
March 2013 – Sep. 2015	Quick Care Las Vegas 3111 S. Maryland Pkwy 89169 LV NV	3840
Title	Description of Duties	Name of Supervisor
Front office receptionist & Billing		Mario Targuilino
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

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: N _____
Date: A _____
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 ☐

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

.....

.....

.....

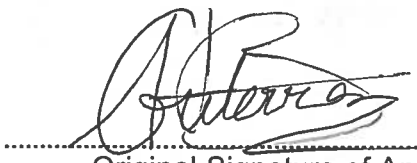
.....

.....

Date c 3/11/2019

I, Angelica Gutierrez, 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 case 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 of 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.



Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 3/27/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 Durable Medical Equipment
Nature of License

Alltime Healthcare 4660 S. Eastern ave ste 100 LV NV 89119
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Carmenate Rivas	Wailin	

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

Present Residence Address-Street or RFD	City	State/Zip
N/A	Rosarito, Las Vegas,	NV 89121 -
2840 E. Flamingo Rd Dates	Las Vegas	NV 89121
Present Business Address	City	State/Zip

Owner Dates
Occupation

Phone: Residence

Business

Date of Birth / Las Tunas, Cuba
Place of Birth (City, County, State)

33 Female
Age Social Security Number Sex

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Black	Brown		172		5.3

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

Are you a citizen of the United States? Yes ☑ No ☐ If alien, registration No ~~11/17/2006~~ N/A

If naturalized, certificate No Date 11/17/2006

Place Las Vegas, Nevada (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial DCR

MARITAL INFORMATION-Continued

A. **Current Marriage** 2/20/2005 (Date) Las Vegas, NV USA (City, County and State)

Spouse's full name (Maiden) Ohan Deivys Gutierrez S.S. No. -

Date of Birth , , Place of Birth Cardenas, Matanzas Cuba

Resident address Rosario Cir (Street) Las Vegas (City) NV (State) 89121 (Zip)

Telephone: Residence , Business

Spouse's employer Self Employ Occupation Driver

Address of employer Amazon Delivery (Street) Las Vegas (City) NV (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
N/A				

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

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Nilieth Gutierrez	, ,	USA	Rosario Cir LV NV
Keilyn Gutierrez	, ,	USA	Rosario Cir LV NV
Angelica Gutierrez	, ,	USA	Spring Rain Rd LV NV

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 DCR

FAMILY INFORMATION-Continued

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

Name .....

Address .....

Contact person .....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Norberto Carmenate Sanchez	/ /		Deceased.
Mother	Margarita Rivas Acuña	/ /	Palora Ave LV. NV 8911	
Father-in-Law	Enrique Ramirez Pelegrin	/ /	Palora Ave LV NV 89169	
Mother-in-Law				

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
	Deyker Carmenate Rivas	/ /	Palora Ave LV NV	Packer.
Spouse	Yoilin Torres Guerra	/ /	Same Address	Unemploy.
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	El Dorado Highschool	Las Vegas, NV	1999/2003	Yes ☐ No ☑
High School	Valley Highschool	Las Vegas NV		Yes ☐ No ☑
College University	Las Vegas College	Las Vegas. USA!	2003/2005	Yes ☑ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any Bookkiping

College or university where obtained Las Vegas college.

Applicant's initial DCR.

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 or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial.....

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. 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:

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
12/2013 - Present	Rosario cir	Las Vegas,	Nevada USA
12/2012/12/2013 -	? Aracatuba Ave	Las Vegas,	Nevada USA
2013 - 2013	2900 Olive St Apt 11	Las Vegas	NV USA
2009 - 2011	500 S. Maryland Pkwy	Las Vegas	
2005 - 2009	1924 Golden Arrow Dr	LV	NV 89169
1990 - 2005	4801 Lakestream Ave	LV	NV 89

Applicant's initial DCR

8. 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
01/2015	Express Tax Services 2840 E. Flamingo Rd	Owner. n/A.
Title	**Description of Duties**	**Name of Supervisor**
Owner	tax preparer -	Self.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2019 to 04/2017	At your Services Home Care. 1785 E. Sahara Ave LVNV	No more client
Title	**Description of Duties**	**Name of Supervisor**
Personal Care	Visit client help w/daily Basic.	Fernando.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2014/04-17.	AM/PM Home Care 820 Rancho LN LV NV 89106	Better Salary.
Title	**Description of Duties**	**Name of Supervisor**
Personal Care	Visit clients help w/daily Care Basic.	—

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
06/2005/-12/2013	The Venetian Hotel 3355 S. LV Blvd.	Looking for a better business
Title	**Description of Duties**	**Name of Supervisor**
Attendent	Restock mini Bar in Hotel Rooms.	See Bastian.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/18-Present	Allstate Ins. 3265 E. Tropicana Ave	still employed.
Title	**Description of Duties**	**Name of Supervisor**
Sales	Sale ins. Policys.	Yolanda Sitto.

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**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial DCR.

9. 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 Leandro Ramirez	Home	Paluca	CA	NV 89169	:	lot.
Employer Wynn Hotel	Business	3131 S. Las Vegas Blvd			702-770-7000	10+
Name Laura Senda	Home	: Bel Port Dr		89110		5½+
Employer All State Ins	Business	3265 E. Tropicana Ave E-1		LV NV		
Name Yolanda Citlu	Home	' Montagna Dr		LV NV 89134		6 years
Employer All state Ins	Business	3265 E. Tropicana Ave E-1		LV NV		7029087450
Name Yusimi Betarte	Home	E. Imperial Ave		LV NV 89104		10 years
Employer Amazon Delivery	Business					
Name Yosbel Tamas	Home	E. Imperial Ave.				
Employer Self Employed	Business	Self Employed				6 years

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. 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

Sales Insurance, Las Vegas, NV 1/24/2017

✓12. Have you ever applied for a city, county of 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.

Soleproper - Express tax Services - Las Vegas, NV
Tax Preparation Preparer - 2015 - Present.
2840 E. Flamingo Rd Suite Las Vegas, NV 89121

Applicant's initial DCR.

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☑

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

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

15. 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 ☑

16. 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 ☑

17. 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/or controlled substances? Yes ☐ No ☑

18. 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 close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

A1

Date of photograph 3/11/19

Applicant's initial DCR

STATE OF Nevada
ss.
COUNTY OF Clark

I, Dailin Carmenate Rivas, 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 case for denial or revocation of a manufacturer 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

State of Nevada
County of Clark

X
Original Signature of Applicant

Subscribed and Sworn to before me this 28th day of March 2019

Dailin Carmenate-Rivas

Notary Public

JOHN ACEVES
Notary Public - State of Nevada
County of Clark
APPT. NO. 08-7219-1
My App. Expires Sep. 1, 2020
(seal)

Applicant's initial DCR

ADDITIONAL INFORMATION

Applicant's initial DCR

12B

4:12

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Otto Bock Orthopedic Services LLC

Physical Address: 2780 S. Jones Blvd Ste 140 Las Vegas, NV 89146-5641

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

Mailing Address: 11501 Alterra Pkwy Ste 600 - Attn Jessica Salatino

City: Austin State: Texas Zip Code: 78758-3597

Telephone: 512-806-2628 Fax: 866-642-2302

E-mail: US-OS-NPRC-Department@ottobock.com. Website: www.ottobockus.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9:00 to 3:30 Tue: 9:00 to 3:30 Wed: 9:00 to 3:30 Thu: 9:00 to 3:30

Fri: 9:00 to 3:30 Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Sharon Clark

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: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Tim Alonzi Telephone: 248-470-5413

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

MEDICARE #
AZ- 633760003Y
CO - 633760 0009
FL- 63376000 27
IL- 63376000 33
MD- 6337600037
MI- 6337600029
NC- 633760 00 30

MEDICARE
OH- 6337600032
OK- 6337600036
PA- 6337600031
TX- 6337600001
TX- 6337600018
UT- 6337600035

MEDICAID
AZ- 44552-5
WI - 10004351 0
OK- 2000 49510 D
MI- 8668690
PA- 102409 3690004
MD- 0332691
TX- 2119 14103
UT- 3009687
NC- 1104206 499

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 ■

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ■ No ☐

3) Are any of the owners health professionals? If yes, please check the box and list name.

☐ Practitioner	Name: N/A
☐ Advanced Practitioner of Nursing	Name: N/A
☐ Physician's Assistant	Name: N/A
☐ Physical Therapist	Name: N/A
☐ Occupational Therapist	Name: N/A
☐ Registered Nurse	Name: N/A
☐ Respiratory Therapist	Name: N/A

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 questions 1 through 5 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 or 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Danilo Sarria
Print Name of Authorized Person

4/09/19
Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Minnesota

Parent Company if any: Otto Bock HealthCare North America INC.

Corporation Name: Otto Bock HealtHcare North America INC.

Mailing Address: 11501 Alterra Pkwy Suite 600

City: Austin State: Texas Zip: 78758-3597

Telephone: 800-328-4058 Fax: 866-642-2302

Contact Person: _____

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) See Attached
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. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses.*

2) Provide the number of shares issued by the corporation. See attached

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 corporation's stock register evidencing the above information

APPLICATION FOR NEVADA MDEG LICENSE

NON PUBLICLY TRADED CORPORATION

Include with the application for a non publicly traded corporation

Complete personal history record for each stockholder.. Must be original signature(s), no copies or stamps. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

Certificate of Corporate status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors.

ottobock.

March 27, 2019

Nevada State Board of Pharmacy
431 W Plumb Lane
Reno, NV 89505

Dear Nevada State Board of Pharmacy,

I am submitting our Medical Device Equipment and Gases application for our **Prosthetic/Orthopedic/DME Division, Otto Bock Orthopedic Services LLC (Tax ID#: 32-0288792).** In regards to Page 5a, Question 1, we are wholly owned by Otto Bock Healthcare NA, Inc. **(Tax ID#: 41-0824465).** We are not publicly traded, nor do we have publicly issued shares. I am attaching out current W9 to further support the chain of ownership of our organization. If you have any additional questions, please do not hesitate to contact me.

Kindest Regards,

Jessica Salatino
Billing Operations Project Manager
11501 Alterra Parkway
Suite 600
Austin, Texas 78758-3597
Phone: 512.806.2628
Jessica.Salatino@ottobock.com

Ottobock Orthopedic Services, LLC
11501 Alterra Parkway
Suite 600
Austin, TX 78758

T 800 711 2205
www.ottobockus.com

Office of the Minnesota Secretary of State

Minnesota Limited Liability Company/Annual Renewal

Minnesota Statutes, Section 5.34

Annual Renewal Year:	**2018**
Annual Renewal Filing Date:	**12/10/2018**
Corporation Name:	**Otto Bock Orthopedic Services LLC**
Original Filing Number:	**3397306-2**
Home Jurisdiction:	**Minnesota**

Filing Party Information:

Party Type:	Name:	Address:
Manager	**Andreas Schultz**	**11501 Alterra Parkway Suite 600 Austin TX 78758**
Principal Executive Office Address		**11501 Alterra Parkway Suite 600 Austin TX 78758**
Registered Agent	**Corporation Service Company**	
Registered Office Address		**2345 Rice Street Suite 203 Roseville MN 55113**

Work Item 1052932400021
Original File Number 3397306-2

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
FILED
12/10/2018 11:59 PM

Steve Simon
Secretary of State

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 3/29/19

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
Nature of MDEG

Otto Bock Orthopedic Services LLC - 2780 S. Jones Blvd., Suite 140, Las Vegas, NV 89146-5641
Name and Address of Business for Which MDEG Administrator Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Hamilton (Last Name) | Irma Gloria (First Name) | (Middle Name)

Irma Gloria Peralta, Gloria Hamilton
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Autumn Haze (Present Residence Address-Street or RFD) | Las Vegas (City) | NV 89117 (State/Zip)

2780 S Jonas Blvd, Suite 140 (Present Business Address) | Dates | Las Vegas (City) | NV 89146 (State/Zip)

Service Center Administrator (Present Position with the MDEG) | Dates

Phone: 800-736-8276 Fax: 866-632-2303

Email address: US_OS_NPRC_Department@ottobock.com

(Date of Birth) | San Diego, San Diego, CA (Place of Birth (City, County, State))

61 (Age) | (Social Security Number) | F (Sex)

Brown (Color of Eyes) | Brown (Color of Hair) | 145 lbs (Weight) | 5'4" (Height)

Scars, tattoos or distinguishing marks and/or characteristics None

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.

	Prime Health Care dba West Anaheim Med Ctr	
03/2016-03/2019	3033 W Orange Ave, Anaheim , CA 92804	6200 hours
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Insurance Verifier	Verification of patient insurances	Billy Cevallos
Title	Description of Duties	Name of Supervisor
	Discover Wellness Health Association	
01/2009-03/2016	438 E Katella Ave, Suite B Orange, CA 92867	14,000 hours
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Medical Billing Mgr	Medical Billing and Claims	Kristie Niang
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

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:
b)

State: _____

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 ☐

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

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.....

AT H

Date of photograph 3/28/19

I, Irma Gloria Hamilton, 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 case 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 of 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.

Irma Gloria Hamilton

Original Signature of Applicant

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE for a Pharmacy or Wholesaler located in Nevada

Date 3/27/2019

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 Durable medical equipment, prosthetics, orthotics and supplies
Nature of Pharmacy or Wholesaler

Otto Bock Orthopedic Services LLC: 2780 S. Jones Blvd, Suite 140 Las Vegas, NV 89146
Name and Address of Business for Which Designated Representative Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Sarria — Danilo — —
Last Name — First Name — Middle Name

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

Stratus Drive — Dripping Springs, TX 78620
Present Residence Address-Street or RFD — City — State/Zip

11501 Alterra Parkway Suite 600 — Dates — Austin, TX 78758
Present Business Address — City — State/Zip

VP of Operations — Dates
Present Position with the Pharmacy or Wholesaler

Phone:
Residence
Business 480-281-2234

Date of Birth — Place of Birth (City, County, State)

50 — M
Age — Social Security Number — Sex

BROWN	BROWN	WHITE	215	ATHLETIC	6'2"
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 1/15/88

Place PHOENIX, AZ (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial DS

A. **Current Marriage** 2/14/99 (Date) PHOENIX, MARICOPA, ARIZONA (City, County and State)

Spouse's full name (Maiden) CORY L. S.S. No

Date of Birth Place of Birth CEDAR RAPIDS, IA

Resident address 9524 STRATUS DRIVE (Street) DRIPPING SPRINGS (City) TX (State) 78620 (Zip)

Telephone: Residence Business 602-301-8388

Spouse's employer SELF-EMPLOYED Occupation REALTOR

Address of employer 9524 STRATUS DRIVE (Street) DRIPPING SPRINGS (City) TX (State) 78620 (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
ROBIN SARRIA	07/1994	PHOENIX AZ	DIVORCE	PHOENIX, MARICOPA, AZ

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

Name	Street	City	State	Zip	Telephone
ROBIN BISHOP	7 FARGO LN	LINCOLN	CA	95648	( )

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
MORGAN LIEBER	/ /	SACRAMENTO, CA	BARNHILL LN LINCOLN CA 95648
EMILY SARRIA	/ /	SCOTTSDALE, AZ	STRATUS DRIVE DRIPPING SPRINGS, TX 7862
JULIANA SARRIA	/ /	SCOTTSDALE, AZ	STRATUS DRIVE DRIPPING SPRINGS, TX 7862
ANA SARRIA	/ /	SCOTTSDALE, AZ	STRATUS DRIVE DRIPPING SPRINGS, TX 78620

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 DS

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, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	UNKNOWN			
Mother	ADOPTED MOTHER ANA TOBON	/ /	DECEASED	
Father-in-Law	GEORGE KNOTT II		DECEASED	
Mother-in-Law	BARBARA CORY	- / / ?	15.7TH ST #316 PHOENIX, AZ 85040	RETIRED

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
N/A			
Spouse			
Spouse			
Spouse			
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	EDISON ELEMENTARY	PHOENIX, AZ	1980-1982	Yes ☑ No ☐
High School	CAMELBACK HIGH SCHOOL	PHOENIX, AZ	1982-1986	Yes ☑ No ☐
College University	ARIZONA STATE UNIVERSITY	TEMPE, AZ	1998-2004	Yes ☑ No ☐
Other	UNIVERSITY OF PHOENIX	PHOENIX, AZ	2004-2009	Yes ☑ No ☐

Type of degree obtained, if any MASTERS OF BUSINESS ADMINISTRATION

College or university where obtained UNIVERSITY OF PHOENIX

Applicant's initial

5 MILITARY INFORMATION:

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

Branch MARINE CORPS Date of entry-active service 4/88

Date of separation 5/89 Type of discharge HONORABLE DISCHARGE

Rating at separation PFC Serial number [redacted]

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☑ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☐ No ☑ ENLISTED IN SERVICE

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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial [redacted]

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a 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. 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:

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
06/2015 - PRESENT	1 STRATUS DRIVE	DRIPPING SPRINGS,	TX
07/2014 - 06/2015	4125 SUGARLOAF DRIVE	AUSTIN, TX	TX
04/2012 - 07/2014	5223 S. BIG HORN PL	CHANDLER	AZ
05/2005 - 04/2012	16654 S. 27TH AVE.	PHOENIX	AZ
05/2003 - 05/2005	2937 W. SILVER FOX	PHOENIX	AZ
10/1999 - 05/2003	455 W. MOUNTAIN SAGE	PHOENIX	AZ
10/1997 - 10/1999	1100 E. OSBORN RD	PHOENIX	AZ
10/1995 - 10/1997	1501 W. VERNON AVE	PHOENIX	AZ
08/1983 - 10/1995	1751 E. CAMBRIDGE AVE	PHOENIX	AZ

Applicant's initial _____

8. EMPLOYMENT:

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

05/2008	OTTOBOCK 11501 ALTERRA PARKWAY, SUITE 600 AUSTIN, TX 78758	22,880 HOURS
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
VP, OPERATIONS	EXECUTIVE DIRECTOR OF ORTHOPEDIC SERVICES	ANDREAS SCHULTZ
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial DS

9. 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	Y	K	n
Name JON SCHWARTZ	Home	? E. MARLETTE AVE	PHOENIX,	AZ	85016	40		
Employer STATE OF ARIZONA	Business	AZ SUPREME COURT JUDGE						
Name ANN ADAMS	Home	S. CARRIAGE LN	CHANDLER,	AZ	85286	25		5
Employer REALTOR/BROKER	Business	ANN ADAMS & ASSOCIATES						
Name GEORGE BAXTER	Home	? N LAKE PLEASANT RD	PEORIA,	AZ	85382	37		
Employer U.S. POSTAL SERVIC	Business	POSTAL SUPERVISOR						
Name TEESHA MARTIN	Home	5 E NORTHRIDGE ST.	MESA,	AZ	85213	11		
Employer VALLEY SLEEP CENTER	Business	OPERATIONS MANAGER						
Name ANNE WALMSLEY	Home	BLAIRSVILLE HWY	MURPHY,	NC	28903	8		
Employer ADVANCED ORTHO	Business	DIRECTOR OF SALES (ORTHOTICS)						

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 of 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 for any reason whatsoever? Yes ☑ No ☐
NEVADA BOARD OF PHARMACY

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

If yes to the above, state where, when and for what reason:
NEVADA BOARD OF PHARMACY MFG LICENSE IN 2010 WHICH WAS APPROVED FOR OUR FORMER LOCATION IN LAS VEGAS

Applicant's initial JS

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 ☑

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 ☑

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/or controlled substances? Yes ☐ No ☑

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 close of a wholesaler Yes ☐ No ☑

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler? Yes ☑ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☑ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes ☐ No ☑

Date of photograph 3/30/19

Applicant's initial DS.

STATE OF Texas
ss.
COUNTY OF Travis

I, DANILO SARRIA, 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 case for denial or revocation of a wholesaler 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

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 wholesaler in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 2nd day of April, 2019

Notary Public

JOHN D. PRICE
Notary Public, State of Texas
Comm. Expires 04-11-2022
Notary ID 128226294

Applicant's initial

Applicant's initial.....

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 04/05/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 _____
Nature of License

_____
Name and Address of Establishment for Which License Is Requested

_____
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

SCHULTZ | ANDREAS | LUDWIG
Last Name | First Name | Middle Name

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

PLEASANT PANORAMA VIEW | AUSTIN | TX 78738
Present Residence Address-Street or RFD | City | State/Zip

11501 ALTERRA PKWY | Dates | AUSTIN | TX 78758
Present Business Address | City | State/Zip

CFO | Dates
Occupation

Phone:
Residence _____
Business 6127351172

CELLE, GERMANY
Date of Birth | Place of Birth (City, County, State)

50 | [redacted] | MALE
Age | Social Security Number | Sex

BLUE | BLOND/GREY | FAIR | 220lbs | 6'1"
Color of Eyes | Color of Hair | Complexion | Weight | Build | Height

Scars, tattoos or distinguishing marks and/or characteristics _____

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 AS

A. **Current Marriage** 12/22/05 (Date)

Spouse's full name (Maiden) GLORIA CONGHUYEN (City, County and State) S.S. No

Date of Birth [illegible] Place of Birth SILVER SPRING, MD

Resident address 1 PLEASANT PANORAMA VIEW AUSTIN TX 78738
Street City State Zip

Telephone: Residence Business

Spouse's employer ✓ Occupation HOMEMAKER

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

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

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
KAIA SCHULTZ	[illegible]	HOUSTON, TX	1 PLEASANT PANORAMA VW AUSTIN, TX 78738
AXEL SCHULTZ	[illegible]	ZURICH, SWITZERLAND	11

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 AS

FAMILY INFORMATION-Continued

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

Name .....

Address .....

Contact person .....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	LUDWIG SCHULTZ		1 GÖCKENHOLZ/GERMANY	DECEASED
Mother	EDELGARD SCHULTZ		1 LACHENDORF/GERMANY	RETIRED
Father-in-Law	PHILIP VINH QUOC		0 BEECHNUT #4202 HOUSTON TX 77083	RETIRED
Mother-in-Law	BICH NGOC NGUYEN		0 BEECHNUT #4202 HOUSTON, TX 77083	RETIRED

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	MICHAELA KRUSCHELWSKI		7 CELLE/GERMANY	LAW CLERK
Spouse				
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School				Yes ☐ No ☐
High School	BFBS I	CELLE, GERMANY	1989-1990	Yes ☒ No ☐
College University	FH OFFENBURG	OFFENBURG	1991-1995	Yes ☒ No ☐
Other	UNIVERSITY OF CHICAGO	CHICAGO	2000-2002	Yes ☒ No ☐

Type of degree obtained, if any EXECUTIVE MBA

College or university where obtained U OF CHICAGO

Applicant's initial AS

5 MILITARY INFORMATION:

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

Branch TANK DIVISION 95 Date of entry-active service 10/01/1988

Date of separation 09/30/1989 Type of discharge REGULAR

Rating at separation ✓ Serial number ✓

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☒ If yes, furnish details on page 10. (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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. 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 not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial AS

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a 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. 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:

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
06/25/2016 – CURRENT	PLEASANT PANORAMA VW	AUSTIN,	TX 78738
09/01/2014 – 06/24/2016	14308 SENIA BEND	AUSTIN	TX 78738
06/25/2014 – 08/31/2014	3501 RR 620 #25001	AUSTIN	TX 78738
12/21/2010 – 06/24/2014	17817 63RD AVE N	MAPLE GROVE	MN 55311
04/17/2010 – 12/20/2010	15337 PORCHLIGHT LN	EDEN PRAIRIE	MN 55347
01/18/2008 – 04/16/2010	BERGSTRASSE 22	RUSHORGEN	SWITZERLAND 8810
09/01/2006 – 01/17/2008	5901 EVERGREEN ST.	MIDLAND	MI 48642
07/05/2004 – 08/31/2006	3030 POST OAK BLVD.	HOUSTON	TX 77056
09/01/1998 – 07/04/2004	SCHÖNBÜHLSTR. 10	ZÜRICH	SWITZERLAND 8032
10/01/1993 – 08/31/1998	FEUERGASSE 13	GENGENBACH	GERMANY 77723

Applicant's initial AS

8. 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
01/01/2010	OTTOBOCK HC LP 11501 ALTERRA PKWY #600, AUSTIN, TX 78758	
Title	**Description of Duties**	**Name of Supervisor**
CFO	FINANCIAL + SHARED SERVICES OVERSIGHT	BRAD RUHL
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
01/01/1995	DOW EUROPE SA BACHTOBELSTRASSE 3, CH-8810 HORGEN	BETTER OPPORTUNITY
Title	**Description of Duties**	**Name of Supervisor**
SR. FINANCE MANAGER	ECONOMIC EVALUATION	CECILIA FALCO
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
06/1991-09/1991	UNEMPLOYED	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
01/1991-05/1991	RPC, BREMERWEG 205 29223 CELLE, GERMANY	- UNIVERSITY
Title	**Description of Duties**	**Name of Supervisor**
WORKER	LOGISTICS ACTIVITIES	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
10/1990-12/1990	UNEMPLOYED	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
07/1989-09/1989	UNEMPLOYED	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
08/1986-07/1988	HÖBEL UNGER, CLOSED	COMPLETED APPRENTICE
Title	**Description of Duties**	**Name of Supervisor**
SALESMAN	APPRENTICESHIP TO SALESMAN	DIETER LOWAG
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial AS

9. 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 SANDRA BACA	Home	W. LINDA LN. CHANDLER	AZ	85224		7 years
Employer SEBE	Business	HEALTHCARE				
Name TEESHA MARTIN	Home	E. NORTHRIDGE ST. MESA,	AZ	85213		8 years
Employer VALLEY SLEEP CENTER	Business	HEALTHCARE				
Name AUNE WALMSLEY	Home	BLAIRSVILLE HWY MURPHY	NC	28903		8 years
Employer ADVANCED [illegible]	Business	HEALTHCARE				
Name RALF KRÜGER	Home	[illegible]			WÄDENSWIL	20 years
Employer DOW EUROPE	Business	CHEMICAL				
Name KRIS FISHMAN	Home	SPRINGWATER DR. JUPITER,	FL	33458		9 years
Employer WELLS PHARMACY	Business	HEALTHCARE				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. 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

12. Have you ever applied for a city, county of 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.

Applicant's initial AS

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

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

15. 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 ☒

16. 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 ☒

17. 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/or controlled substances? Yes ☐ No ☒

18. 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 close of a manufacturer Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒

Date of photograph

Applicant's initial AS

STATE OF Texas
ss.
COUNTY OF Travis

I, ANDREAS SCHULTZ, 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 case for denial or revocation of a manufacturer 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 of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 9th day of April, 2019

Notary Public

JOHN D. PRICE
Notary Public, State of Texas
Comm. Expires 04-11-2022
Notary ID 128226294

(seal)

Applicant's initial AS

Applicant's initial AS

12C

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

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

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation □ Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☑ Non Publicly Traded Corporation □ Pages 1,2,3,5a,5b ☐ Sole Owner □ Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Providence Medical Supply

Physical Address: 1729 E Charleston Blvd # F Las Vegas 89104

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

Mailing Address: 1729 E Charleston Blvd # F

City: Las Vegas State: NV Zip Code: 89104

Telephone: 702-982-0078 Fax: 702 485 6332

E-mail: Dype6@yahoo.com Website: N/A

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 6 Tue: 9 to 6 Wed: 9 to 6 Thu: 9 to 6

Fri: 9 to 6 Sat: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Modupe Ivorobeji

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: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: _____ Telephone: _____

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

1558824607 _____ _____

1154703905 _____ _____

_____ _____ _____

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 ☑

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☑

3) Are any of the owners health professionals? If yes, please check the box and list name.

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

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, 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 questions 1 through 5 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 or 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

MOBUPE IRORO BEJE — Print Name of Authorized Person

4/10/2019 — Date

Board Use Only	Received:	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Corporation Name: Divine Providence Inc

Mailing Address: 11055 Kilkenny Ct

City: Las Vegas State: NV Zip: 89141

Telephone: 9546631759 Fax: _____

Contact Person: Dr. Medupe Ivorobeje

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

100% a) Medupe Ivorobeje 11055 Kilkenny Ct. Las Vegas 89141
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. Download the form from the website under the New Applications tab. The forms are available under the *documents for all types of businesses*.

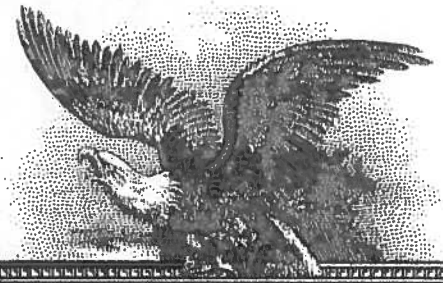
2) Provide the number of shares issued by the corporation. 75,000

3) What was the price paid per share? No Par value

4) What date did the corporation actually receive the cash assets? 03/20/2013

5) Provide a copy of the corporation's stock register evidencing the above information

505



NUMBER 75,000

SHARES 100%

DIVINE PROVIDENCE INC.

INCORPORATED UNDER THE LAWS OF THE STATE OF NEVADA 2013
AUTHORIZED CAPITAL SEVENTY FIVE THOUSAND :(75,000) SHARES OF COMMON STOCK WITH NO PAR VALUE

This Certifies that Modupe Inuwaje is the registered holder of _____ Shares

FULLY PAID AND NON-ASSESSABLE SHARES OF THE CAPITAL STOCK OF SAID CORPORATION

transferable only on the books of the Corporation by the holder hereof in person or by Attorney upon surrender of this Certificate properly endorsed.

In Witness Whereof, the said Corporation has caused this Certificate to be signed by its duly authorized officers and its Corporate Seal to be hereunto affixed this 20th day of March A.D. 2013

SECRETARY

PRESIDENT

© GOES KG2

(PROFIT) INITIAL/ANNUAL LIST OF OFFICERS, DIRECTORS AND STATE BUSINESS LICENSE APPLICATION OF:

DIVINE PROVIDENCE INC
NAME OF CORPORATION

ENTITY NUMBER
E0137082013-1

FOR THE FILING PERIOD OF MAR, 2019 TO MAR, 2020

100103

USE BLACK INK ONLY - DO NOT HIGHLIGHT

****YOU MAY FILE THIS FORM ONLINE AT www.nvsilverflume.gov****

☐ Return one file stamped copy. (If filing not accompanied by order instructions, file stamped copy will be sent to registered agent.)

Filed in the office of	Document Number
Barbara K. Cegavske	20190192003-97
Barbara K. Cegavske Secretary of State State of Nevada	Filing Date and Time 05/01/2019 12:03 PM
	Entity Number E0137082013-1

(This document was filed electronically.)
ABOVE SPACE IS FOR OFFICE USE ONLY

IMPORTANT: Read instructions before completing and returning this form.

1. Print or type names and addresses, either residence or business, for all officers and directors. A President, Secretary, Treasurer, or equivalent of and all Directors must be named. There must be at least one director. An Officer must sign the form. *FORM WILL BE RETURNED IF UNSIGNED.*
2. If there are additional officers, attach a list of them to this form.
3. Return the completed form with the filing fee. Annual list fee is based upon the current total authorized stock as explained in the Annual List Fee Schedule For Profit Corporations. A $75.00 penalty must be added for failure to file this form by the deadline. An annual list received more than 90 days before its due date shall be deemed an amended list for the previous year.
4. State business license fee is $500.00/$200.00 for Professional Corporations filed pursuant to NRS Chapter 89. Effective 2/1/2010, $100.00 must be added for failure to file form by deadline.
5. Make your check payable to the Secretary of State.
6. Ordering Copies: If requested above, one file stamped copy will be returned at no additional charge. To receive a certified copy, enclose an additional $30.00 per certification. A copy fee of $2.00 per page is required for each additional copy generated when ordering 2 or more file stamped or certified copies. Appropriate instructions must accompany your order.
7. Return the completed form to: Secretary of State, 202 North Carson Street, Carson City, Nevada 89701-4201, (775) 684-5708.
8. Form must be in the possession of the Secretary of State on or before the last day of the month in which it is due. (Postmark date is not accepted as receipt date.) Forms received after due date will be returned for additional fees and penalties. Failure to include annual list and business license fees will result in rejection of filing.

CHECK ONLY IF APPLICABLE AND ENTER EXEMPTION CODE IN BOX BELOW

☐ Pursuant to NRS Chapter 76, this entity is exempt from the business license fee. Exemption code: ☐

NOTE: If claiming an exemption, a notarized Declaration of Eligibility form must be attached. Failure to attach the Declaration of Eligibility form will result in rejection, which could result in late fees.

NRS 76.020 Exemption Codes
001 - Governmental Entity
006 - NRS 680B.020 Insurance Co

☐ This corporation is a publicly traded corporation. The Central Index Key number is:

☐ This publicly traded corporation is not required to have a Central Index Key number.

NAME	TITLE(S)			
MODUPE A IROROBEJE	PRESIDENT (OR EQUIVALENT OF)			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	
NAME	TITLE(S)			
MODUPE A IROROBEJE	SECRETARY (OR EQUIVALENT OF)			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	
NAME	TITLE(S)			
MODUPE A IROROBEJE	TREASURER (OR EQUIVALENT OF)			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	
NAME	TITLE(S)			
MOUPE A IROROBEJE	DIRECTOR			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	

None of the officers or directors identified in the list of officers has been identified with the fraudulent intent of concealing the identity of any person or persons exercising the power or authority of an officer or director in furtherance of any unlawful conduct.

I declare, to the best of my knowledge under penalty of perjury, that the information contained herein is correct and acknowledge that pursuant to NRS 239.330, it is a category C felony to knowingly offer any false or forged instrument for filing in the Office of the Secretary of State.

X MODUPE A IROROBEJE
Signature of Officer or Other Authorized Signature

Title PRESIDENT

Date 5/1/2019 12:03:14 PM

Nevada Secretary of State List Profit
Form: 100103 Revised: 7-1-17

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

DIVINE PROVIDENCE INC

Nevada Business Identification # NV20131166246

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on May 1, 2019

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law cannot be waived.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 4/10/19

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 associates 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 Medical Supply
Nature of MDEG

Providence Medical Supply 1729 E Charleston Blvd #F 89104
Name and Address of Business for Which MDEG Administrator Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Irorobeje | Modupe | Ajoke
Last Name | First Name | Middle Name

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

Kilkenny Ct | Las vegas | NV 89141
Present Residence Address-Street or RFD | City | State/Zip

1729 E Charleston Blvd HF Dates | las vegas | NV 89104
Present Business Address | City | State/Zip

CEO/Administrator Dates 2013- Present
Present Position with the MDEG

Phone: 702 982 6678 Fax: 702 485 6332

Email address: Providence medical supply1@gmail.com

Date of Birth | Lagos, Nigeria
Place of Birth (City, County, State)

39 | | F
Age | Social Security Number | Sex

Brown | Black | 170 | 5'3"
Color of Eyes | Color of Hair | Weight | Height

Scars, tattoos or distinguishing marks and/or characteristics None

Are you a citizen of the United States? Yes ☑ No ☐

If alien, registration No

If naturalized, certificate No Date 02/22/2013

Place Las Vegas NV (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.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
11/2013 - Present	Providence Pharmacy 1729 E Charleston Blvd #F Las Vegas NV 89104	45 hours/week
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	verification of Medications & Medical Inventory supplies to patients	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

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 ☐ 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 ☐

If you answer No to questions 4, 5 or 6 pleas explanation.

.....

.....

.....

.....

.....

HOTOGRAPH

VITHIN LAST

'S HERE

Date of photograph 4/29/19

I, Modupe Irowbeji, 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 case 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 of 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.

Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 4/10/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or 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. 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 DME (MDEG)
Nature of License

Providence Medical Supply 1729 E Charleston Blvd #F las vegas 89104
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Irorobeje	Modupe	Ajoke

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

Present Residence Address-Street or RFD	City	State/Zip
Kilkerran Ct	las vegas	NV 89141

Present Business Address	Dates	City	State/Zip
1729 E Charleston Blvd		las vegas	NV 89104

Occupation	Dates	Phone: Residence / Business
Pharmacist	2013 - Present	702-982-0078

Date of Birth	Place of Birth (City, County, State)
39	Lagos, Nigeria

Age	Social Security Number	Sex
		Female

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Brown	Black	Black	170	Average	5'3"

Scars, tattoos or distinguishing marks and/or characteristics None

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

If naturalized, certificate No [redacted] Date 2/22/2013

Place Las Vegas NV (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial MAI

MARITAL INFORMATION-Continued

A. **Current Marriage** 12/13/2007 (Date) las vegas, Clark, NV (City, County and State)

Spouse's full name (Maiden) Friday Ironbeji S.S. No

Date of Birth Place of Birth Ughelli, Nigeria

Resident address Kilkenan Ct las vegas NV 89141
Street City State Zip

Telephone: Residence Business 702 945 4202

Spouse's employer HealthCare Partners Occupation Nurse Practitioner

Address of employer 821 N Nellis Blvd Las vegas NV 89110
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
N/A				

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

Name	Street	City	State	Zip	Telephone
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
Jeremiah Ironbeji		las vegas NV	Kilkenan Ct. las vegas 8914
Oghenegoma Ironbeji	11	11	11
Oghenemuno Ironbeji	11	11	11

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 MMI

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, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Bankole Braithwaite			Deceased
Mother	Cecilia Thomas		Kilkenny Ct las vegas 89141	Retired
Father-in-Law	Michael Inowbeji		Akpodiete St. Ughelli North Delta State	Retired
Mother-in-Law	Grace Inowbeji		Akpodiete St. Ughelli North Delta State	Retired

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
	Mobolaji Braithwaite		Miami Drive FL 33162	Customs Service
Spouse	Sylvia Braithwaite		Miami Drive FL 33162	House wife
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Maryland Convent Primary School		1985-1991	Yes ☑ No ☐
High School	Maryland Comprehensive Sec. School		1991-1997	Yes ☑ No ☐
College University	Florida Memorial University			Yes ☐ No ☐
Other	Miami Gardens FL 33054			Yes ☑ No ☐

Type of degree obtained, if any Pharm D 2007-2010

College or university where obtained Rosemann College of Health Sciences 11 Sunset way henderson NV 89014

Applicant's initial MMA

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 or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (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 or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☑ If yes, give details in space provided below. List all cases without exception.

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

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☑ If yes. furnish details on page 10.

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, furnish details on page 10.

Name	Relationship	Charge	Location	Date
		N/A		

Applicant's initial NMH

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a 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. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
Defendant- Bankruptcy	4/12/2010	10-16337-MKn	las Vegas NV	7/21/2010

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:

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

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
05/2003 - 08/2005	18068 SW 30th Ct	Miramar	Fl 33029
08/2005 - 08/2007	1020 NW 155 lane #305	Miami	Fl 33054
08/2007 - 12/2007	1100 N Center St #1825	Henderson	Nv 89015
01/2008 - 04/2011	5501 E Harmon Ave #5	Las Vegas	Nv 89122
05/2011 - 12/2017	3540 Tundra Swan St.	las vegas	Nv 8912
12/2017 - Present	Killaman Ct.	las vegas	Nv 89141

Applicant's initial MH

8. 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
11/2013 - 04/19	Providence Pharmacy	Sold the business
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Pharmacy Manager	Medhya Inamdar
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
01/12 - 08/14	Walmart Pharmacy	Left to open my business
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Pharmacist	
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
10/2010 - 01/2012	CVS Pharmacy	Switched Companies
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Pharmacist	Rhonda Lundgard
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
04/2011 - 10/2011	Advanced Care Pharmacy	Part time
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	4161 S Eastern Avenue las vegas nv 89119	Jeny
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
05/2005 - 04/2006	Interactive Response Technology	
Title	**Description of Duties** 2989 N. Commerce Pkwy miramar fl	**Name of Supervisor**
Customer Service Rep.	Answering questions about phone services	
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
05/1998 - 04/2005		Full time Student
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**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial MAT

9. 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 Nazalene Zebari	Home			Teton Ranch Ave	89052	7 years
Employer N/A	Business			N/A		
Name Felix Egbase	Home			Opal Cove Dr	89128	10 years
Employer Kindred Hosp	Business	5110 W Sahara		Las Vegas	89146	
Name Zeb Igelke	Home	5 Rainbow Blvd # 110			89145	10 years
Employer Alpha b Accounting	Business	222 S Rainbow Blvd # 110			89145	
Name Rose Stiffin	Home	NW 42nd Ave			FL 33054	16 years
Employer Florida Memorial Uni	Business	University Professor			78729	
Name Armelle Quedraogo	Home	3 Hunter Chase Dr # 424				15 years
Employer State of Texas	Business	Accounting				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A			

11. 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

N/A

12. Have you ever applied for a city, county of 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.

N/A

Applicant's initial NAE

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☑

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

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

15. 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 ☑

16. 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 ☑

17. 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/or controlled substances? Yes ☐ No ☐

18. 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 close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

Date of photograph 4/29/19

Applicant's initial MMF

STATE OF Nevada
ss.

COUNTY OF Clark

I, Modupe Ironbeji, 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 case for denial or revocation of a manufacturer 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 of fraudulent, and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their 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 their agents, as a result of my applying for a manufacturer license in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this 1st day of May 2019

Mariam Jane Hasso
Notary Public

MARIAM JANE N. HASSO
Notary Public, State of Nevada
Appointment No. 15-2958-2
My Appt. Expires Jun 8, 2019

(seal)

Applicant's initial MAI

ADDITIONAL INFORMATION

N/A

Applicant's initial

13

CONTINUING EDUCATION CHECKLIST

Program Name: Adult Mental Health First Aid

Date of Program: Various times and dates from 2019-2020

Number of CE hours being requested 8 *accredited/acceptable(circle one)*

Name of Person Requesting Approval: Angela Friedman

Contact Address: 4600 Kietzke Lane, B-114

Reno, NV 89502

Contact Phone#: 775-684-2240

Before the Continuing Education Committee for the Nevada State Board of Pharmacy gives approval, the board office must receive the following materials at least sixty (60) days before the program is presented.

X Copy of materials to be distributed to participants

X CV or equivalent information on presenter(s)

X Program syllabus or specifications/objectives of the program

_____ Statement certificate will be provided to participants

-or-

X Copy of certificate presented to participants

_____ Statement evaluation form will be provided to participants for the purpose of evaluating program materials

-or-

X Copy of evaluation form

If any information is missing everything will be returned.

****

***FOLLOW-UP**: Within 60 days after the program, a list of pharmacist participants must be received at the board office. This list of pharmacists can be mailed prior to receiving notification of approval.*

****

FOR OFFICE USE ONLY

_____ *Date Received by Board Office*

Mental Health First Aid® Timing Guide – w/o Opioid Section – 8 Hours

The Mental Health First Aid Timing Guide is provided to support instructors with guidance on how to pace the delivery of the course. The Timing Guide provides the content divided into instructional segments along with duration, slide numbers, and activities for each segment. While instructors may choose the length of breaks, the course itself must include 8 hours of instruction.

Session	Topic	Duration	Slides	Exercises & Discussions
	Pre-Course Preparation	-	-	*Print and post Ground Rules and Parking Lot prior to course; MH Opinions Quiz Prior to Course*
Session 1 Part 1	Introductions Overview of MHFA Course & Manual	25 minutes	1–3	
	What is MHFA Why MHFA What is a Mental Disorder	20 minutes	4–6	Why MHFA Brainstorm Negative Terms Who Can Diagnose
	Prevalence of Mental Disorders Disability & Recovery MHFA Action Plan	25 minutes	7–10, 11	Prevalence Disability Weights
	Depression & Anxiety Signs & Symptoms of Depression	30 minutes	12–16	A-Z Depression & Anxiety DVD: Pain of Depression
	Anxiety Disorders Prevalence Signs & Symptoms	30 minutes	17–23	Illustrations of Anxiety Risk Factors for Depression & Anxiety
Break		15 minutes		
Session 1 Part 2	MHFA Action Plan Assess for Risk of Suicide Warning Signs of Suicide	50 minutes	24–30	Helpful Things to Say Myths & Fact About Suicide & NSSI Ask the Question
	Non-Suicidal Self Injury	20 minutes	31–33	Reasons for Non-Suicidal Self-Injury Medical Emergencies
	MHFA Action Plan—ALGEE	45 minutes	34–40	MHFA Action Plan
Lunch		30 minutes		
Session 2 Part 1	Panic Attack	20 minutes	41–45	Panic Attack Demonstration
	Traumatic Event	25 minutes	46–49	What is a Traumatic Event Impact of Trauma
	Psychosis	40 minutes	50–57	Myths & Misunderstandings Auditory Hallucination Exercise
	MHFA for Psychosis	45 minutes	58–68	DVD: MHFA for Psychosis Demonstrate Neutral Stance
Break		15 minutes		
Session 2 Part 2	Substance Use Disorders	30 minutes	69–75	FAQs About Alcohol Risk Factors
	MHFA for Substance Use	20 minutes	76–85	Stages of Change: *Brief Discussion*
	Concluding Activities	35 minutes	86–87	Scenario—Full Action Plan
	Evaluation & Wrap Up	20 minutes		MHFA Quiz *Online Evaluations* Graduation
	Total Active hours			

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

Raising Awareness of Behavioral Health & Community Treatment Resources: Mental Health First Aid Act (S. 711/H.R. 1877)

Mental Health First Aid is a public education program that helps parents, first responders, faith leaders, and other people identify, understand, and respond to signs of mental illnesses and substance use conditions. Participants learn a 5-step action plan to reach out to a person in crisis and connect them professional, peer, or other help.

The bipartisan Mental Health First Aid Act (S. 711/H.R. 1877) authorizes $20 million in grants to fund Mental Health First Aid training programs around the country. Participants would be trained in: **Objectives**

- Recognizing the signs and symptoms of common mental illnesses and substance use disorders
- De-escalating crisis situations safely
- Initiating timely referral to mental health and substance use treatment resources available in the community

Why do we need the Mental Health First Aid Act?

Each year, more than one in five Americans experiences a mental illness or substance use disorder. Yet, as a society, we remain largely ignorant about the signs and symptoms, and don't know how to help a person in need.

Our lack of awareness often prevents people who need treatment from getting appropriate care. While many Americans know how to administer First Aid and seek medical help should they come across a person having a heart attack, few are trained to provide similar help to someone experiencing a mental health or substance-use related crisis.

Mental Health First Aid has been shown to increase help-seeking and improve adherence to treatment. Studies have shown that Mental Health First Aid increases help provided to others, increases guidance to professional help, and improves concordance with health professionals about treatment.

We can all benefit. This bipartisan bill would offer training programs to emergency services personnel, police officers, teachers/school administrators, primary care professionals, and others – with the goal of improving Americans' mental health and helping people who may be at risk of suicide or self-harm.

How is this bill different from the $15 million appropriation for MHFA in 2015?
The fiscal year 2015 budget included a $15 million appropriation for Mental Health First Aid. The National Council is grateful to Congress for this support. The Mental Health First Aid Act will help solidify the future of this funding by providing statutory authorization clearly delineating Congressional intent regarding the scope of the program.

Cosponsors *Current as of 5/5/2015*

Mental Health First Aid Act (S. 711)
CO: Michael Bennet (D)
CT: Richard Blumenthal (D) (Lead Sponsor)
CT: Christopher Murphy (D)
DE: Christopher Coons (D)
FL: Marco Rubio (R)
IA: Chuck Grassley (R)
MI: Debbie Stabenow (D)
ND: Heidi Heitkamp (D)
NH: Jeanne Shaheen (D)
NH: Kelly Ayotte (R) (Lead Sponsor)
NV: Dean Hellen (R)
OH: Rob Portman (R)
RI: Jack Reed (D)

Mental Health First Aid Act (H.R. 1877)
CA: Doris Matsui (D-6) (Lead Sponsor)
CA: Anna Eshoo (CA-18)
KS: Lynn Jenkins (R-2) (Lead Sponsor)

SESSION 1 (4 hours)

Objectives of Session 1

Part 1: Teaching Notes pp. 2–25 (120 minutes)

- To introduce Mental Health First Aid (MHFA), the 8–hour training, and the role of a Mental Health First Aider
- To give an overview of the prevalence and impact of mental health problems in the United States
- To introduce the Mental Health First Aid Action Plan and how it fits within the array of interventions available to address mental health problems
- To give an overview of the signs, symptoms, and possible risk factors and warning signs of depression and anxiety

Break

Part 2: Teaching Notes pp. 26–42 (120 minutes)

- To demonstrate the Mental Health First Aid Action Plan for someone who is experiencing depressive symptoms or anxiety and may be in a crisis such as suicide or self-injury
- To explore how to respond to someone who is not in crisis, but may benefit from the additional steps of LGEE

Preparation for Session 1

Organize your teaching venue to have the following equipment:

LCD projector and screen	Laptop computer with DVD slot	External sound speakers	TV and DVD player if no DVD slot in computer
Whiteboard, markers, and eraser	Flip chart and markers	Safe setup of electrical cords	Refreshments

Be sure to have the following teaching materials ready:

MHFA PowerPoint	Film clips DVD	Teaching notes	MHFA manual
MHFA manuals for participants	Handouts for exercises	Class list/sign-in sheet, name tags, pens	"Parking Lot" sheet
Index cards for disability ranking exercise	Agency card or local resources handout	Algee the Koala (optional)	

Symbols Used in Teaching Notes and on Slides

	Slide #		MHFA Manual page ##
	Group activity		Discussion
	Handout		DVD/video
	List continues onto next slide		List on slides is complete
	Background info for instructor		

SESSION 2 (4 hours)

Objectives of Session 2

Part 1: Teaching Notes pp. 44–73

- To briefly review content of Session 1
- To demonstrate the Mental Health First Aid Action Plan for people who are experiencing a panic attack and may be in crisis
- To demonstrate the MHFA Action Plan for people who are experiencing a traumatic event and may be in crisis
- To give an overview of the risk factors and warning signs of psychotic disorders
- To demonstrate the Mental Health First Aid Action Plan for people with symptoms of psychosis or in a related crisis

Break

Part 2: Teaching Notes pp. 74–96

- To give an overview of the risk factors and warning signs of substance use disorders
- To demonstrate the MHFA Action Plan for people with symptoms of a substance use disorder or a related crisis
- To synthesize everything that has been learned in a concluding activity
- Complete the First Aider Exam
- Complete the course evaluation

Preparation for Session 2

Organize your teaching venue to have the following equipment:

LCD projector and screen	Laptop computer with DVD slot	External sound speakers	TV and DVD player if no DVD slot in computer
Whiteboard, markers, and eraser	Flip chart and markers	Safe setup of electrical cords	Refreshments

Be sure to have the following teaching materials ready:

MHFA PowerPoint	Film clips DVD	Teaching notes	MHFA manual
MHFA manuals for participants	Handouts for exercises	Class list/sign-in sheet, name tags, pens	"Parking Lot" sheet
Index cards for disability ranking exercise	Agency card or local resources handout	Algee the Koala (optional)	

Symbols Used in Teaching Notes and on Slides

	Slide #		MHFA Manual page ##
	Group activity		Discussion
	Handout		DVD/vídeo
	List continues onto next slide		List on slides is complete
	Background info for instructor		

ADULT MENTAL HEALTH FIRST AID PARTICIPANT EVALUATION

Location of the course: _____ Dates of the course: _____

Instructor(s): _____

I. Overall Course Evaluation

		Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1.	Course goals were clearly communicated.	1	2	3	4	5
2.	Course goals and objectives were achieved.	1	2	3	4	5
3.	Course content was practical and easy to understand.	1	2	3	4	5
4.	There was adequate opportunity to practice the skills learned.	1	2	3	4	5

I received an official, soft cover-bound Mental Health First Aid USA manual to take home with me. Yes ____ No ____

If No, please explain (i.e. "I received a paper copy of the manual," "I returned my manual to my instructor after class," etc.):

II. A. Presenter Evaluation: Instructor #1 Name: _____

		Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
5.	The instructor's presentation skills were engaging and approachable.	1	2	3	4	5
6.	The instructor demonstrated knowledge of the material presented.	1	2	3	4	5
7.	The instructor facilitated activities and discussion in a clear and effective manner.	1	2	3	4	5
8.	Feedback for this instructor.					

III. B. Presenter Evaluation: Instructor #2 Name: _____

		Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
9.	The instructor's presentation skills were engaging and approachable.	1	2	3	4	5
10.	The instructor demonstrated knowledge of the material presented.	1	2	3	4	5
11.	The instructor facilitated activities and discussion in a clear and effective manner.	1	2	3	4	5
12.	Feedback for this instructor.					

IV. Practical Application

As a result of this training, I feel more confident that I can...	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
13. Recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.	1	2	3	4	5
14. Reach out to someone who may be dealing with a mental health problem, substance use challenge or crisis.	1	2	3	4	5
15. Ask a person whether they're considering killing themselves.	1	2	3	4	5
16. Actively and compassionately listen to someone in distress.	1	2	3	4	5
17. Offer a distressed person basic "first aid" level information and reassurance about mental health and substance use challenges.	1	2	3	4	5
18. Assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help.	1	2	3	4	5
19. Assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer and personal supports.	1	2	3	4	5
20. Be aware of my own views and feelings about mental health problems, substance use challenges and disorders.	1	2	3	4	5
21. Recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them.	1	2	3	4	5

What is your overall response to this course? (Please check all that apply)

- ☐ This course was helpful and informative
- ☐ This course has better prepared me for the work that I do professionally
- ☐ This course did not have a sufficient amount of activities and information to prepare me to be a first aider
- ☐ I did not feel that I benefited from this course
- ☐ Other
- ☐ I choose not to respond

What do you consider to be the strengths of the course? (Please check all that apply)

- ☐ ALGEE and the hands-on practice in class
- ☐ The instructor's presentation style and engagement
- ☐ The length of the course
- ☐ Other
- ☐ I choose not to respond

What do you consider to be the weaknesses of the course? (Please check all that apply)

- ☐ The course was too short and I need more time to practice what I learned
- ☐ The course was too long
- ☐ There were not enough hands-on exercises
- ☐ Other
- ☐ I choose not to respond

Was there any issue or topic you expected this course to cover that it did <u>not</u> address?

Any other comments?

26. Why did you attend this course? (circle all that apply)

a. My employer asked / assigned me
b. Personal interest
c. Other:
d. Other professional development (specify profession)
e. Community or volunteer interest (please specify)

In what role do you see your Mental Health First Aid training being of use? (Check all that apply)

☐ At work (please describe your work position): _____
☐ As a parent / guardian
☐ As a family member
☐ As a peer / friend
☐ As a volunteer / mentor
☐ Other (please describe): _____

Would you recommend this course to others?

Yes If no, **why not?**

How do you describe your race / ethnicity? (Please circle all that apply)

a. American Indian or Alaskan Native
b. Asian
c. Black or African American
d. Hispanic or Latino origin
e. Native Hawaiian or other Pacific Islander
f. Caucasian / White
g. I choose not to respond
h. Other:

What is your age?

- ☐ 18-24 years
- ☐ 25-44 years
- ☐ 45-60 years
- ☐ 61-80 years
- ☐ 81 years or older

What is your gender?

- ☐ Male
- ☐ Female
- ☐ I identify as neither male nor female.

I identify as a person with lived experience or a person in long-term recovery.

- ☐ Yes
- ☐ No

I support a family member with serious mental illness.

- ☐ Yes
- ☐ No

27. How did you hear about this course? (circle all that apply)

a. My employer asked / assigned me
b. Word of mouth, not employer (Who?)
c. Website (Which one?)
d. Email notice (From whom?)
e. Flier or brochure (Obtained where?)
f. Newsletter or bulletin (Which one?)
g. Radio (Which station?)
h. Newspaper (Which paper?)
i. TV (Which station?)
j. Other:

Mental Health First Aid USA

MENTAL HEALTH FIRST AID™

Certificate

PARTICIPANT'S NAME

has completed the 8 hour course and is now certified in

Mental Health First Aid USA

And has been trained to provide initial help to people experiencing mental health problems such as depression, anxiety disorders, psychosis, and substance use disorders.

This certification became effective on: _____
Date

This certification expires on: _____
Date

_____ _____
Instructor Instructor

MISSOURI DEPARTMENT OF MENTAL HEALTH

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

Mental Health First Aid USA is coordinated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

Building a world class organization
Healthy People Healthy Communities
Maryland Department of Health & Mental Hygiene

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

LISA SHERYCH
Interim Administrator, DPBH

IHSAN AZZAM, Ph.D., M.D.
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Bureau of Child, Family and Community Wellness
Office of Suicide Prevention
4600 Kietzke Lane, B-114
Reno, NV 89502
Telephone: (775) 684-2240 · Fax: (775) 689-0565

May 21, 2019

Nevada State Board of Pharmacy
431 West Plumb Lane
Reno, NV 89509

RE: Continuing Education Units for Applied Suicide Intervention Skills Training (ASIST)

To Whom It May Concern:

Please find attached the Continuing Education Checklist Form and back up documents supporting Applied Suicide Intervention Skills Training (ASIST). We request approval to allow your licensees to earn continuing education units for attending ASIST.

The following trainers' resumes have been included in the packet for your review:

Allen, Misty	Jenkins, Henry
Desroche, Kimberly	Leath, Angela
Dough, RJ	Massolo, Janett
Egan, Richard	Nye, Alaine
Gibson, Daela	Ostaszewski, Bryan
Holybee, Stacy	Smyth, Jessica

Please do not hesitate to contact me is you need further information.
Thank you for your consideration.

Sincerely,

Angela Friedman

Angela Friedman
Administrative Assistant IV

CONTINUING EDUCATION CHECKLIST

Program Name: Applied Suicide Intervention Skills Training (ASIST)

Date of Program: Various dates and times throughout the year

Number of CE hours being requested 15.0 *accredited/acceptable(circle one)*

Name of Person Requesting Approval: Angela Friedman, Admin. Asst. IV

Contact Address: 4600 Kietzke Lane, Building B, Suite 114

Reno, NV 89502

Contact Phone#: 775-684-2240

Before the Continuing Education Committee for the Nevada State Board of Pharmacy gives approval, the board office must receive the following materials at least sixty (60) days before the program is presented.

* Copy of materials to be distributed to participants

* LivingWorks Education developed the evidence based material for ASIST which is copyrighted

X CV or equivalent information on presenter(s)

X Program syllabus or specifications/objectives of the program

_____ Statement certificate will be provided to participants

-or-

X Copy of certificate presented to participants

_____ Statement evaluation form will be provided to participants for the purpose of evaluating program materials

-or-

X Copy of evaluation form

If any information is missing everything will be returned.

****

FOLLOW-UP: *Within 60 days after the program, a list of pharmacist participants must be received at the board office. This list of pharmacists can be mailed prior to receiving notification of approval.*

****

FOR OFFICE USE ONLY

_____ *Date Received by Board Office*

ASIST

INTERVENTION TRAINING

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety. Although ASIST is widely used by healthcare providers, participants don't need any formal training to attend the workshop—ASIST can be learned and used by anyone.

ASIST makes a difference

As the world's leading suicide intervention workshop, LivingWorks' ASIST program is supported by numerous evaluations including independent and peer-reviewed studies. Results demonstrate that ASIST helps participants become more willing, ready, and able to intervene with someone at risk of suicide.

ASIST is also proven to reduce suicidality for those at risk. A 2013 study that monitored over 1,500 suicidal callers to crisis lines found that callers who spoke with ASIST-trained counselors were 74% less likely to be suicidal after the call, compared to callers who spoke with counselors trained in methods other than ASIST. Callers were also less overwhelmed, less depressed, and more hopeful after speaking with ASIST-trained counselors.

FOCUS: Suicide intervention training
DURATION: Two days (15 hours)
PARTICIPANTS: Anyone 16 or older
TRAINERS: Two registered trainers per 15–30 participants
LANGUAGES: English, French, Spanish, Inuktitut, and Norwegian; Large print and Braille also available

Goals and objectives

In the course of the two-day workshop, ASIST participants learn to:

- Understand the ways personal and societal attitudes affect views on suicide and interventions
- Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs
- Identify the key elements of an effective suicide safety plan and the actions required to implement it
- Appreciate the value of improving and integrating suicide prevention resources in the community at large
- Recognize other important aspects of suicide prevention including life-promotion and self-care

ASIST trainers

ASIST workshops are facilitated by a minimum of two registered trainers who have completed a five-day *Training for Trainers (T4T)* course. ASIST trainers come from diverse backgrounds, but they must all deliver regular workshops and participate in a rigorous quality control program to remain registered. For information about trainers in your area, email info@livingworks.net. A listing of upcoming workshops is available at www.livingworks.net under "Find a Training."

ASIST participants

ASIST is a resource for the whole community. It helps people apply suicide first-aid in many settings: with family, friends, co-workers, and teammates, as well as formal caregiving roles. Many organizations have incorporated ASIST into professional development for their employees. Its widespread use in various communities creates a common language to understand suicide safety issues and communicate across different organizational backgrounds.

ASIST

INTERVENTION TRAINING

Workshop Process

ASIST is based on adult learning principles. Valuing participants' contributions and experiences, it encourages them to take an active role in the learning process. ASIST's key features include:

Small-group learning	To facilitate involvement, participants spend over half the workshop in a small group with one of the trainers.
Audiovisual aid	High-quality slides, diagrams, and videos help participants understand and memorize concepts.
Training focus	Some participants may have previous personal or professional experience with suicide or intervention. ASIST builds on these experiences to contribute to the overall learning goal—providing suicide first-aid.
Reliable, proven model	Workshop activities are structured around the ASIST intervention model and provide applicable, hands-on skills practice.
Emphasis on individual needs	Participants learn to adapt to the specific circumstances of a person at risk and work collaboratively to help them stay safe.
Perspective matters	Participants are encouraged to reflect on and share their own attitudes about suicide and suicide intervention. This helps them understand how their perspectives may affect their role in providing help to a person at risk.
Direct approach	By encouraging honest, open, and direct talk about suicide, ASIST helps prepare to discuss the topic with a person at risk.
Adaptable components	ASIST trainers can tailor certain features of the program, such as role-playing activities, to meet participants' professional or cultural needs.

11

Updated editions since 1983 for continued growth and improvement

6,300+

ASIST trainers offer workshops in over 30 countries

1,000,000+

people have taken ASIST worldwide

"I use ASIST in virtually every crisis situation, volunteer and work... Thank you for this ***life-changing program***."

—ASIST participant

About LivingWorks: LivingWorks is dedicated to saving lives through the creation, development, and delivery of innovative training experiences that empower individuals, organizations, and communities to be safer from suicide. To learn more, visit **www.livingworks.net.**

LivingWorks | esuicideTALK | suicideTALK | safeTALK | ASIST | suicide to Hope

info@livingworks.net www.livingworks.net **TOLL FREE N.A.** 1.888.733.5484

ASIST

ASIST 11 Trainer Tasks

DATE	WORKSHOP LOCATION	TRAINERS

Day 1

WHO	TIME	DURATION	PREPARING TASK/ACTIVITY (DAY 1)	NOTES
	0830	15 min.	1.1 Registration	Whole Group
	0845	15 min.	1.2 Why First Aid?	Whole Group
	0900	5 min.	1.3 Why ASIST Training is Needed	Whole Group
	0905	15 min.	1.4 About the Participants	Whole Group
	0920	10 min.	1.5 About the Workshop	Whole Group
0930: 10-MINUTE REFRESHMENT BREAK				
	0940	20 min.	1.6 About Connecting and show *Cause of Death?*	Whole Group
	1000	10 min.	Move to workgroups	Workgroup
WHO	**TIME**	**DURATION**	**CONNECTING TASK/ACTIVITY (DAY 1)**	**NOTES**
			2.1 Evening Before, Review the Goals of this Section	Workgroup
	1010	50 min.	2.2 Connecting Feelings and Experiences with Suicide and Helping	Workgroup
	1100	30 min.	2.3 Introductions	Workgroup
	1130	60 min.	2.4 Connecting Attitudes with Suicide and Helping	Workgroup
1230: 1-HOUR MEAL BREAK; RETURN TO WORKGROUPS AFTER BREAK FOR THE UNDERSTANDING SECTION.				
WHO	**TIME**	**DURATION**	**UNDERSTANDING TASK/ACTIVITY (DAY 1)**	**NOTES**
	13:30	10 min.	3.1 Introduction to Understanding	Workgroup
	13:40	15 min.	3.2 Explore Invitations	Workgroup
	13:55	15 min.	3.3 Ask about Thoughts of Suicide	Workgroup
	14:10	10 min.	3.4 Understanding Choices Phase	Workgroup
1420: POSSIBLE BREAK POINT (10 MINUTES)				
	14:30	20 min.	3.5 Hearing their Story	Workgroup
	14:50	20 min.	3.6 Supporting Turning to Safety	Workgroup
	15:10	10 min.	3.7 Assisting Life Phase	Workgroup
	1530	30 min.	3.8 Develop a Safe Plan	Workgroup
	1600	10 min.	3.9 Confirm Actions.	Workgroup
	1610	20 min.	3.10 Concluding Understanding	Workgroup
1630: END OF DAY 1; OFFER TO COLLECT PARTICIPANT WORKBOOKS, ENSURE THAT THEIR NAME IS ON FRONT				

CONTINUED ON REVERSE SIDE

Day 2

WHO	TIME	DURATION	ASSISTING TASK/ACTIVITY (DAY 2)	NOTES
	8:30	15 min.	4.1 Starting the Assisting section.	Whole Group
	8:45	50 min.	4.2 PAL in Action and show It Begins with you	Whole Group
0935: 15-MINUTE REFRESHMENT BREAK				
	9:50	10 min.	4.3 Transition to practice	Whole Group
	1000	10 min.	4.4 Connecting simulation.	Whole Group
	1010	15 min.	4.5 Support Turning to Safety simulation.	Whole Group
	1025	40 min.	4.6 PAL simulation.	Whole Group
	1105	15 min.	4.7 Safety Framework Simulation	Whole Group
	1120	15 min.	4.8 Whole group closing; workgroup introduction.	Whole Group
1135: MOVE TO WORKGROUP WITH 10-MINUTE TRANSITION BREAK				
	1145	45 min.	4.9 Complete at least one practice situations.	Whole Group
1230: 1-HOUR LUNCH BREAK				
	1330	115 min.	4.9 Continuation of practice and conclusion of workgroup activities.	Whole Group
15 MIN: REFRESHMENT BREAK(S) DURING AFTERNOON				
1540: MOVE TO LARGE GROUP FOR WORKING TOGETHER SECTION WITH 5-MINUTE TRANSITION BREAK				
WHO	TIME	DURATION	WORKING TOGETHER/ACTIVITY (DAY 2)	NOTES
			5.1 Organizing and Starting	Whole Group
	1545	20 min.	5.2 Relationships with Persons at Risk discussion.	Whole Group
	1605	15 min.	5.3 Community Relationships discussion.	Whole Group
	1620	10 min.	5.4 Closing and feedback; distribution of certificates, participant list and life assisting sticker	Whole Group
1630: FORMAL END OF WORKSHOP				

* Refer to Table 4.1 and Table 4.2 in the ASIST Trainer Manual for options for whole group activities for two- and three-trainer workshops

Notes/Comments

Applied Suicide Intervention Skills Training (ASIST)

Course Description—

The Applied Suicide Intervention Skills Training (ASIST) workshop is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over 950,000 caregivers have received this training. Just as "CPR" skills make physical first aid possible, training in suicide intervention develops the skills needed for suicide first aid. ASIST is a two-day (15 hours) intensive, interactive and practice-dominated course designed to help caregivers recognize risk and learn how to intervene to prevent the immediate risk of suicide.

The workshop is for all caregivers (any person in a position of trust). This includes professionals, paraprofessionals and lay people. It is suitable for mental health professionals, nurses, physicians, pharmacists, teachers, counselors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers. In ASIST, sophisticated helping concepts are translated into generic language so that different types of caregivers can learn together. Emphasizing structured small-group discussions and practice, the course uses a 20-page workbook and two award-winning audiovisuals. Participants receive a 152-page Suicide Intervention Handbook and a full color, tear-resistant pocket card featuring intervention, and risk review and safeplan development principles. They serve as living refreshers of the workshop learning. ASIST is the most widely used suicide intervention-training program in the world. (Additional information is available as a video clip online at http://www.livingworks.net/flash/asist.html)

Course Content—

The ASIST workshop is divided into five sections, each with defined goals that, in combination, produce individuals who are ready, willing and able to provide suicide "first aid".

1. **Introduction – Preparing:** The goals of this section are as follows: (1) understand that the focus of this workshop is suicide first aid; (2) describe the need for caregivers to be able to do suicide first aid interventions; (3) describe why ASIST is a good way for caregivers to learn suicide first aid; (4) describe the goals and objectives of the workshop; (5) create awareness of the group's experiences with suicidal behaviors; (6) know that group/individual participation are needed to make the workshop succeed.
2. **Attitudes – Connecting:** The goals of this section are for participants to: (1) talk more openly about individual attitudes toward suicide and suicide first aid; (2) recognize how feelings about personal experiences with suicide might affect suicide first aid interventions; (3) identify beliefs that might make it difficult to be direct and comfortable in suicide situations. Identify beliefs that might be helpful in suicide first aid interventions.
3. **Knowledge – Understanding:** The goal of this section is to begin preparing participants to use the Suicide Intervention Model (SIM) by understanding how SIM meets the intervention needs of persons at risk. By completing this section, participants will be able to: (1) recognize SIM as a tool for meeting the intervention needs of the person at risk; (2) name the six basic caregiver tasks of SIM and explain how these tasks address the concerns of a person at risk; (3) understand how to use the Risk Review and Safeplan Guide.
4. **Intervention Skills – Assisting:** The goal of this section is to help participants feel more ready, willing, and able to assist a person at risk. By completing this section, participants will be able to: (1) recognize SIM as a tool that helps participants combine attitudes, knowledge and intervention skills in order to provide suicide first aid; (2) understand SIM; (3) use SIM to help a person at risk of suicide.
5. **Resources – Networking:** The goal of this section is to have participants commit to help with the networking of their community. By completing this section, participants will be able to: (1) complete the identification of existing community resources; (2) be optimistic about the possibility of building resource networks for persons at risk of suicide; (3) understand how ASIST supports the development of resource networks; (4) recognize the value of personal resource networks and other self-care ideas for caregivers.

Course Activities—the ASIST workshop has been developed using the principles of adult-learning. The following are the core training processes and activities used in ASIST.

1. **Lectures:** There are only two places in the workshop in which the lecture format is used for any long period of time.
2. **Mini-lectures:** Mini-lectures are information pieces that take only a few minutes to present. They are used in the Understanding section, in presenting the summaries of the whole group simulations, and for the ending of the workshop in the Networking section.

3. **Open-ended questioning:** Open-ended questions are used to start discussions. They are used in the Connecting section.
4. **Socratic questioning:** Socratic questions are used to help the participants appreciate the value of their individual and collective understanding of suicide.
5. **Simulation experiences:** There are a number of simulation experiences in ASIST, both in whole group and work group settings. Throughout these simulations, participants have the opportunity to intervene with a trainers and participants role-playing persons at risk for suicide by practicing the SIM in various ways.
6. **Running simulations:** A running simulation is a special type of simulation that is regularly stopped to give time for questions, comments, and discussions. The two simulations in the Understanding section are of this type.
7. **Commenting through restatements and summaries:** Comments can be helpful to add to the learning process. The purpose of the restatements and summaries is to help participants integrate learning.

Required Texts, Readings, and Instructional Resources.

ASIST Workbook.

Intervention model wallet cards.

Audiovisual demonstrations of Suicide First Aid Intervention

Suicide Intervention Handbook.

Implementation of Skills:

By utilizing the above training processes throughout the ASIST workshop, participants are able to see, hear, and learn the information and skills needed to provide suicide first aid. They have the opportunity to practice these skills in both large group and small workgroup formats by the end of the course.

Evaluation of ASIST:

The Applied Suicide Intervention Skills Training workshop has undergone extensive evaluation in Canada, United States, Scotland, Ireland, Northern Ireland, Australia and Norway. ASIST is regarded as evidenced based (Macro International (2008) *Cross-site Evaluation of the Garrett Lee Smith Suicide Prevention and Early Intervention Program, Training Utilization and Penetration Interviews (TUP): Applied Suicide Intervention Skills Training (ASIST), January 29-30, 2008.* Salem: Oregon Department of Human Services) and as reflecting best practices (Best Practices for the Suicide Prevention Resource Center in the United States). Further evaluation information can be obtained on the LivingWorks website at www.livingworks.net .

Acknowledgements

This training is offered through a partnership between the Nevada Coalition for Suicide Prevention and the State of Nevada's Office of Suicide Prevention.

ASIST

Applied Suicide Intervention Skills Training

ASIST participant feedback:

"I use ASIST in virtually every crisis situation, volunteer and work. Thank you for this life-changing program."

"My overall level of confidence in dealing with this type of situation increased 100% both in knowledge and skills."

"Workshop was great. High participation and involvement. The most practical counseling training."

Questions? Call!

Janett Massolo
Office of Suicide Prevention
445 Apple St. # 104
Reno, NV 89502

Phone 775-688-2964x261
Fax 775-689-2067
Email = jmassolo@dhhs.nv.gov

Nevada Coalition for Suicide Prevention & Office of Suicide Prevention

ASIST Workshop

Registration Information

March 25 & 26, 2014
8:00-5:00

Willow Springs Outpatient Services
650 Edison Way
Reno, Nevada 89502

ASIST Workshop Information

Thank you for your interest in attending this special presentation of Applied Suicide Intervention Skills Training (ASIST). ASIST is designed for caregivers seeking to prevent the immediate risk of suicide. The emphasis of the ASIST workshop is on suicide first aid. **The workshop is 2 full days, 8 hours each day; please consider this when registering for the workshop.** No partial credit will be given: you must fully attend and participate in order to receive a certificate and/or CE credits.

At the end of the workshop, participants will be able to:

- Recognize invitations for help
- Reach out and offer support
- Review the risk of suicide
- Apply a suicide intervention model
- Link persons at risk with community resources

Training Schedule

Registration Begins at 8:00 a.m. both days
Program Begins at 8:30 a.m. and ends at 4:30 p.m. on both days.
Breakfast/Lunch and refreshments will be provided.

CE Credit

Continuing Education credits (12 -13.5 hrs) are available for the following Nevada boards: Alcohol, Drug & Gambling Counselors, Marriage & Family Therapists and Clinical Professional Counselors, Psychologists, and Social Work Board. Board of Education approves 1 credit.

Meet Your Trainers....

Misty Allen, MA

Misty is the Suicide Prevention Coordinator for the State of Nevada's Office of Suicide Prevention. She has more than 15 years of experience in suicide prevention, intervention and postvention. Misty has been a registered trainer of ASIST since 2006

Janett Massolo

Janett is the Youth Suicide Prevention Program Assistant for the State of Nevada's Office of Suicide Prevention. She has more than 15 years of experience in crisis intervention and Suicide intervention, prevention and postvention efforts for the suicide prevention hotline. Janett has been a registered trainer of ASIST since 2009.

On Training Day...

- *ASIST* is an intervention skills training; please be prepared to practice.
- The subject of suicide may elicit certain reactions; the safety and confidentiality of all participants is maintained throughout the workshop.
- Dress comfortably, as the workshop is interactive; you will be working in small and large group settings.
- All training materials are provided; you may want to bring a pen, pencil and/or highlighter for note-taking.
- At the conclusion of the training, you will complete a lengthy evaluation; this is a requirement of our federal grant and of the LivingWorks program.
- **In order to receive CEUs and/or a certificate of completion, you must attend both, full days of training and complete the evaluation. No credit is given for partial attendance.**
- If you wish to network with other participants, you may bring business cards or other contact information.

Your cooperation in these matters will help ensure an effective and efficient training experience for everyone - thank you!

Registration Form

ASIST - March 25 & 26, 2014- Reno, Nevada

Please Print Legibly

Name:_____

Address:_____

_____

Phone:_____

E-mail:_____

Employer:_____

Profession:_____

License Type & #:_____

REGISTRATION & PAYMENT DEADLINE= Monday--3/17/2014

Due to class size we urge you to get your registration done as soon as possible.
Thank you!!

Payment Information

☐ Early-Bird $75 (March 7, 2014)

☐ Regular $85

No refunds if cancelled after March 14, 2014

Make checks payable to:
Nevada Coalition for Suicide Prevention

To register: Submit a completed registration form and payment to:
Nevada Coalition for Suicide Prevention
445 Apple St. # 104
Reno, Nevada 89502

Special Accommodations

Please contact OSP if you have any need for special accommodations.

ASIST

Your Feedback

WORKSHOP DATE	WORKSHOP LOCATION	NAME OF WORKGROUP TRAINER

Please circle the letter next to your primary role/job (please select only one).

a. Administrator	b. Firefighter	c. Volunteer	d. Police/Corrections
e. Clergy/Pastoral	f. Youth Worker	g. Psychologist	h. Military Branch: _____
i. Counselor	j. Nurse	k. Social Worker	l. Chaplain/Assistant Military Branch: _____
m. Educator	n. Physician	o. Transit Worker	p. Other (specify):

Have you attended an ASIST workshop before? ❑ Yes ❑ No

On a scale of 1 to 10, please write the rating number that best describes your response to the questions.	Rating
1. How would you rate ASIST? (1 = did not like at all...10 = liked a lot)	
2. Would you recommend ASIST to others? (1 = definitely no...10 = definitely yes)	
3. This workshop has practical use in my personal life. (1=definitely no...10=definitely yes)	
4. This workshop has practical use in my work life. (1=definitely no...10=definitely yes)	

Please circle the number that describes your response.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide.	1	2	3	4	5
6. Before taking the ASIST training, my answer to #5 would have been:	1	2	3	4	5
7. If someone told me he or she were thinking of suicide, I would do a suicide intervention.	1	2	3	4	5
8. Before taking the ASIST training, my answer to #7 would have been:	1	2	3	4	5
9. I feel prepared to help a person at risk of suicide.	1	2	3	4	5
10. Before taking the ASIST training, my answer to #9 would have been:	1	2	3	4	5
11. I feel confident I could help a person at-risk of suicide.	1	2	3	4	5
12. Before taking the ASIST training, my answer to #11 would have been:	1	2	3	4	5

Please place a check mark in the appropriate box.

13. I attended two consecutive 8-hour days of training. (Including lunch hour)	❑ Yes	❑ No
14. All trainers were present at the workshop for the full 2 days.	❑ Yes	❑ No
15. The "Jack" exercise was done on the afternoon of day 1.	❑ Yes	❑ No

Please write any additional comments you may have about the ASIST workshop or clarify any of your responses.

ASIST

Applied Suicide Intervention Skills Training

[Participant Name]

has completed the ASIST workshop in suicide first aid

Date: [Date]
Location: [Location]
Duration: 15 hours

SIGNATURE

LivingWorks
suicide-safer communities · saving lives for tomorrow
www.livingworks.net

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

LISA SHERYCH
Interim Administrator, DPBH

JOHN DIMURO, D.O., MBA
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Bureau of Child, Family and Community Wellness
Office of Suicide Prevention
4600 Kietzke Lane, B-114
Reno, NV 89502
Telephone: (775) 684-2240 · Fax: (775) 689-0565

May 21, 2019

Nevada State Board of Pharmacy
431 West Plumb Lane
Reno, NV 89509

RE: Continuing Education Units for Youth Mental Health First Aid (YMHFA) training

To Whom It May Concern:

Please find attached the Continuing Education Checklist Form and back up documents supporting Youth Mental Health First Aid (YMHFA) training. We request approval to allow your licensees to earn continuing education units for attending YMHFA.

The following trainers' resumes have been included in the packet for your review:

Allen, Misty	Lewis, Alicia
Delap, Trey	Mack, Novlette
Dennis, Mike	Martinez, Mary Ann
Egan, Richard	Massolo, Janett
Fortson-Cox, KimTari	Pietershanski, Linda
Johnson, Kim	Ostaszewski, Bryan
Junior, Esther	Ripsom, Susan
Knuppe, Dana	Shelly, Edward

Please do not hesitate to contact me is you need further information.
Thank you for your consideration.

Sincerely,

Angela Friedman
Administrative Assistant IV

CONTINUING EDUCATION CHECKLIST

Program Name: Youth Mental Health First Aid (YMHFA)

Date of Program: Various times and dates throughout the year

Number of CE hours being requested 8.0 *accredited/acceptable (circle one)*

Name of Person Requesting Approval: Angela Friedman, Admin. Asst. IV

Contact Address: 4150 Technology Way, Suite 101

Carson City, NV 89706

Contact Phone#: 775-684-2240

Before the Continuing Education Committee for the Nevada State Board of Pharmacy gives approval, the board office must receive the following materials at least sixty (60) days before the program is presented.

*_____ Copy of materials to be distributed to participants

✔* _____ *National Council on Behavioral Health developed this copyrighted evidence based material

✔ _____ CV or equivalent information on presenter(s)

✔ _____ Program syllabus or specifications/objectives of the program

_____ Statement certificate will be provided to participants

✔ _____ ***-or-***

Copy of certificate presented to participants

_____ Statement evaluation form will be provided to participants for the purpose of evaluating program materials

✔ _____ ***-or-***

Copy of evaluation form

If any information is missing everything will be returned.

****

***FOLLOW-UP**: Within 60 days after the program, a list of pharmacist participants must be received at the board office. This list of pharmacists can be mailed prior to receiving notification of approval.*

****

FOR OFFICE USE ONLY

_____ *Date Received by Board Office*

Youth Mental Health First Aid® Timing Guide

The Youth Mental Health First Aid Timing Guide is provided to support instructors with guidance on how to pace the delivery of the Youth course. The Timing Guide provides the content divided into instructional segments along with duration, slide numbers, and activities for each segment. While instructors may choose the length of breaks, the course itself must include 8 hours of instruction.

DURATION	TOPIC	SLIDE(S)	EXERCISES & DISCUSSIONS
20 Mins	Welcome	1	Ice Breaker Ground Rules Parking Lot
20 Mins	Overview of the Youth MHFA Course Overview of the Youth MHFA Manual Overview of Youth Mental Health First Aid What is Your Role?	2 to 6	Mental Health Opinions Quiz How can MHFA Help Our Communities? Why Youth Mental Health First Aid?
60 Mins	Youth Mental Health Problems in the United States Prevalence of Mental Disorders Adolescent Development Resiliency Youth MHFA and the Spectrum of Interventions Youth MHFA Action Plan	7 to 17	What are Mental Health Problems/Illnesses/ Disorders? Find Your Match Age of Onset: Get Up & Go Typical Adolescent Development Range of Interventions
75 Mins	Signs and Symptoms Nonsuicidal Self-Injury	18 to 23	Mental or Physical A-Z Film: Kevin Hines – Signs and Symptoms Auditory Hallucinations
Suggested Stop for Break (Duration to be added to Schedule)			
40 Mins	Risk Factors for Developing a Mental Health Disorder Protective Factors	24 to 25	Resilience Q&A
25 Mins	Youth MHFA Action Plan Action 'A' – Assess for Risk of Suicide or Harm	26 to 29	Reviewing ALGEE
End Session 1 – Suggested Stop for Lunch (Duration to be added to Schedule)			
25 Mins	What Do You Do? Using the ALGEE Action Plan Approaching the Youth Action 'L' – Listen Nonjudgmentally	30 to 31	Scenario Scene One Listening/Not Listening
25 Mins	Action 'G' – Give Reassurance and Information	32 to 33	Helpful and Unhelpful Reassurance and Information Scenario Scene Two
25 Mins	Action 'E' – Encourage Appropriate Professional Help	34 to 38	Types of Professionals or Treatment
25 Mins	Action 'E' – Encourage Self-Help and Other Support Strategies	39 to 41	Useful Supports for Youth With Symptoms of a Mental Health Disorder Film: Kevin Hines – The ALGEE Action Plan Scenario Scene Three
Suggested Stop for Break (Duration to be added to Schedule)			
80 Mins	Youth Mental Health First Aid for Crisis Situations Action 'A' – Assess for Risk of Suicide or Harm	42 to 51	Types of Crises Fact, Fiction or Somewhere in Between: Youth Suicide & Self-Injury Suicide Warning Signs Film: Kevin Hines – The Day of the Attempt Asking the Question
35 Mins	Other Crises Taking Care of the First Aider	52 to 53	Panic Attack Role Play Crisis Scenario Taking Care of the First Aider
25 Mins	Wrapping Up the Youth MHFA Course	54 to 55	Revisit the Mental Health Opinions Quiz Youth Mental Health First Aid Exam Evaluations and Certificates

YOUTH MENTAL HEALTH FIRST AID

What Is Youth Mental Health First Aid?

Youth Mental Health First Aid is a public education program focused on equipping adults who work with youth (ages 12-18) who may be experiencing a mental health challenge or in a crisis

You will learn.....

- The course teaches participants the risk factors and warning signs of a variety of mental health challenges common among adolescents, including anxiety, depression, psychosis, eating disorders, AD/HD, disruptive behavior disorders, and substance use disorder.
- Participants do not learn to diagnose, nor how to provide any therapy or counseling.
- Participants learn a core five-step action plan to support an adolescent developing signs and symptoms of mental illness or in an emotional crisis:
- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Teaching Methodology

- Mental Health First Aid uses role-playing and simulations to demonstrate how to assess a mental health crisis, select interventions and provide initial help; and connect young people to professional, peer, social, and self-help care

Who Developed Youth Mental Health First Aid

- Mental Health First Aid USA worked with experts at the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development to adapt the Australian youth manual for US audiences.
- The curriculum was developed by the three partners that manage the Mental Health First Aid USA which include National Council for Behavioral Health, Missouri Department of Mental Health and Maryland Department of Mental Health & Hygiene.

This training is for:

The course is designed for adults whom regularly interact with adolescents, but may also be appropriate for older adolescents (16 and older) so as to encourage youth peer to peer interaction. Anyone who regularly works or interacts with youth – teachers, athletic coaches, mentors, juvenile justice professionals – may find the course content useful. The core Mental Health First Aid course has been successfully offered to a variety of audiences including hospital staff, employers and business leaders, faith communities, law enforcement, and the general public.

Note: Youth Mental Health First Aid is <u>not</u> specifically designed for parents of youth with mental health challenges. Although parents & families may find the course content useful, the course provides a basic level of information and guidance, rather than more in-depth information on navigating the healthcare system, which parents may wish to explore.

If you are interested in increasing your skills to better serve people you care for...

Similar to traditional First Aid and CPR, Mental Health First Aid is providing help to a person with a mental health problem or someone experiencing a crisis until professional treatment is obtained or until the crisis is resolved.

YMHFA Training

(This is an 8 hour training taking place on)

January 22 (Wednesday) from 8:00 am to 5:00 pm

Willow Springs Outpatient Services
650 Edison Way, Reno, NV

This is a free training sponsored by the Washoe County Children's Health Consortium. We have room for 25 but it will fill up fast so please get your registration in as soon as possible.

Please complete this registration form and fax or email to the contact listed below.
You will receive confirmation of your registration by email.

Registration

Name_____

Email Address _____

Phone Number _____

Agency_____

Please scan/email this registration form no later than January 15th to jmassolo@health.nv.gov or fax it to 775-689-2067. If you have any questions please feel free to contact Janett Massolo at the Office of Suicide Prevention 775-688-2964 x 261

MENTAL HEALTH FIRST AID USA

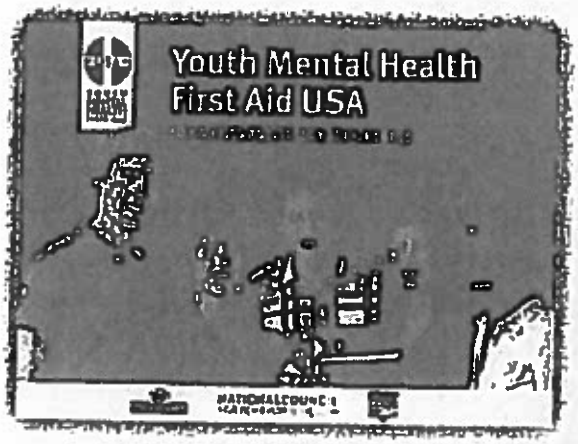
Youth Mental Health First Aid

Youth Mental Health First Aid USA is an 8 hour public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help an adolescent in crisis or experiencing a mental health challenge. Mental Health First Aid uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect young people to professional, peer, social, and self-help care.

Mental Health First Aid is included on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP).

WHAT WILL PARTICIPANTS LEARN?

The course teaches participants the risk factors and warning signs of a variety of mental health challenges common among adolescents, including anxiety, depression, psychosis, eating disorders, AD/HD, disruptive behavior disorders, and substance use disorder. Participants do not learn to diagnose, nor how to provide any therapy or counseling – rather, participants learn to support a youth developing signs and symptoms of a mental illness or in an emotional crisis by applying a core five-step action plan:



- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

The Youth Mental Health First Aid USA curriculum is primarily focused on information participants can use to help adolescents and transition-age youth, ages 12-18.

WHO SHOULD TAKE THE COURSE?

The course is designed for adults who regularly interact with adolescents (teachers, school staff, coaches, youth group leaders, parents, etc.), but is being tested for appropriateness within older adolescent groups (16 and older) so as to encourage youth peer to peer interaction. In January 2013, President Obama recommended training for teachers in Mental Health First Aid. The core Mental Health First Aid course has been successfully offered to more than 100,000 people across the USA, including hospital staff, employers and business leaders, faith communities, law enforcement, and the general public.

WHO CREATED THE COURSE?

Mental Health First Aid USA is coordinated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Since 2008, more than 100,000 individuals have taken the core Mental Health First Aid USA course, which is intended for all adult audiences. Mental Health First Aid USA worked with experts at the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development to develop the youth program.

WHERE CAN I LEARN MORE?

To learn more about the Mental Health First Aid USA, or to find a course or contact an instructor in your area, visit www.MentalHealthFirstAid.org.

Youth MENTAL HEALTH FIRST AID
Course Evaluation Form

Location of the MHFA course:_____
Dates of MHFA course:_____
MHFA Instructor(s):_____

I. Overall Course Evaluation

		Strongly Disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
1.	Course goals were clearly communicated.	1	2	3	4	5
2.	Course goals & objectives were achieved.	1	2	3	4	5
3.	Course content was practical and easy to understand.	1	2	3	4	5
4.	There was adequate opportunity to practice the skills learned.	1	2	3	4	5

II. A. Presenter Evaluation: Instructor _____

		Strongly Disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
5.	The instructor's presentation skills were engaging and approachable.	1	2	3	4	5
6.	The instructor demonstrated knowledge of the material presented.	1	2	3	4	5
7.	The instructor facilitated activities and discussion in a clear and effective manner.	1	2	3	4	5
8.	Feedback for <u>this</u> instructor?					

III. B. Presenter Evaluation: Instructor _____ (Leave blank if only one instructor)

		Strongly Disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
9.	The instructor's presentation skills were engaging and approachable.	1	2	3	4	5
10.	The instructor demonstrated knowledge of the material presented.	1	2	3	4	5
11.	The instructor facilitated activities and discussion in a clear and effective manner.	1	2	3	4	5
12.	Feedback for <u>this</u> instructor?					

IV. Practical Application

	As a result of this training, I feel more confident that I can...	*Strongly Disagree*	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
13.	Recognize the signs that a young person may be dealing with a mental health challenge or crisis.	1	2	3	4	5
14.	Reach out to a young person who may be dealing with a mental health challenge.	1	2	3	4	5

15.	Ask a young person whether s/he is considering killing her/himself.	1	2	3	4	5
16.	Actively and compassionately listen to a young person in distress.	1	2	3	4	5
17.	Offer a distressed young person basic "first aid" level information and reassurance about mental health problems.	1	2	3	4	5
18.	Assist a young person who may be dealing with a mental health problem or crisis to seek professional help.	1	2	3	4	5
19.	Assist a young person who may be dealing with a mental health problem or crisis to connect with appropriate community, peer, and personal supports.	1	2	3	4	5
20.	Be aware of my own views and feelings about mental health problems and disorders.	1	2	3	4	5

21. What is your overall response to this course?

22. What do you consider to be the strengths of the course?

23. What do you consider to be the weaknesses of the course?

24. Was there any issue/topic you expected this course to cover which it did not address?

25. Why did you attend this course? (circle all that apply)

a.	My employer asked/assigned me	f.	Other professional development *(specify profession)*
b.	Personal interest	g.	Community or volunteer interest *(please specify)*
e.	Other:		

26. In what role do you see your Mental Health First Aid training being of use? (check all that apply):

- ☐ At work (please describe your work position): _____
- ☐ As a parent/guardian
- ☐ As a family member
- ☐ As a peer/friend
- ☐ As a volunteer/mentor
- ☐ Other (please describe): _____

27. Would you recommend this course to others? ___Yes ___No

28. What is your gender? ____ Male ____ Female

29. How do you describe your race / ethnicity? (Please circle all that apply)

a.	American Indian or Alaskan Native	e.	Native Hawaiian or other Pacific Islander
b.	Asian	f.	Caucasian / White
c.	Black or African American	g.	Other:
d.	Hispanic or Latino origin		

30. What is your age?

a.	16-24 years	b.	25-44 years	c.	45-60 years	d.	61-80 years	e.	81 years or older

Youth Mental Health First Aid USA

YOUTH MENTAL HEALTH FIRST AID™

Certificate

has completed the 8 hour course and is now certified in

Mental Health First Aid USA

And has been trained to provide initial help to young people experiencing mental health problems such as depression, anxiety disorders, psychosis, and substance use disorders.

This certification became effective on: _____
Date

This certification expires on: _____
Date

Instructor _____ Instructor _____

MISSOURI DEPARTMENT OF MENTAL HEALTH

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

Youth Mental Health First Aid USA is coordinated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

LISA SHERYCH
Interim Administrator, DPBH

IHSAN AZZAM, Ph.D., M.D.
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Bureau of Child, Family and Community Wellness
Office of Suicide Prevention
4600 Kietzke Lane, B-114
Reno, Nevada 89502
Telephone: (775) 684-2240 · Fax: (775) 689-0565

May 22, 2019

Nevada State Board of Pharmacy
431 West Plumb Lane
Reno, NV 89509

RE: Continuing Education Units for safeTALK suicide prevention training

To Whom It May Concern:

Please find attached the Continuing Education Checklist Form and back up documents supporting safeTALK suicide prevention training. We request approval to allow your licensees to earn continuing education units for attending safeTALK.

The following trainers' resumes have been included in the packet for your review:

Allen, Misty	Lewis, Alicia
Basanez, Skyler	Martinez, Mary Ann
Carlson, Eric	Massolo, Janett
Carlson, Jessica	Mendenhall, Thomas
Decola, Tina	Mony, Chelsey
Desroche, Kimberly	Ostaszewski, Bryan
Dough, RJ	Pritchard, Trina
Egan, Richard	Sanchez, Julian
Gibson, Daela	Scholl, Marlyn
Holybee, Stacy	Shoop, Heather
Johnson, Kim	Washabaugh, Melissa
Leath, Angela	

Please do not hesitate to contact me if you need further information. Thank you for your consideration.

Sincerely,

Angela Friedman
Administrative Assistant IV

CONTINUING EDUCATION CHECKLIST

Program Name: safeTALK(**s**uicide **a**wareness **f**or **e**veryone **T**ell, **A**sk, **L**isten, **K**eep safe)

Date of Program: Various dates and times throughout the year

Number of CE hours being requested 4.0 *accredited/acceptable(circle one)*

Name of Person Requesting Approval: Angela Friedman, Admin. Asst. IV

Contact Address: 4600 Kietzke Lane, B-114

Reno, NV 89502

Contact Phone#: 775-684-2237

Before the Continuing Education Committee for the Nevada State Board of Pharmacy gives approval, the board office must receive the following materials at least sixty (60) days before the program is presented.

* Copy of materials to be distributed to participants
* LivingWorks Education developed the evidence based material for safeTALK which is copyrighted

X CV or equivalent information on presenter(s)

X Program syllabus or specifications/objectives of the program

_____ Statement certificate will be provided to participants

-or-

X Copy of certificate presented to participants

_____ Statement evaluation form will be provided to participants for the purpose of evaluating program materials

-or-

X Copy of evaluation form

If any information is missing everything will be returned.

****

***FOLLOW-UP**: Within 60 days after the program, a list of pharmacist participants must be received at the board office. This list of pharmacists can be mailed prior to receiving notification of approval.*

****

FOR OFFICE USE ONLY

_____ *Date Received by Board Office*

safeTALK: suicide alertness for everyone

safeTALK is a half-day training in suicide alertness. It helps participants recognize a person with thoughts of suicide and connect them with resources who can help them in choosing to live. Participants don't need any formal preparation to attend the training—anyone age 15 or older who wants to make a difference can learn the safeTALK steps.

FOCUS: Suicide alertness training for the community
DURATION: 3 hours–4 hours (half a day)
LANGUAGES: English and French
PARTICIPANTS: Anyone 15 or older
TRAINERS: One trainer and one community resource person per 15–30 participants

How safeTALK works

Most people with thoughts of suicide don't want to die—instead, they are looking for a way to work through the pain in their lives. Through their words and actions, they usually invite others to help them in making a choice for life. safeTALK teaches participants to recognize these invitations, engage with the person with thoughts of suicide, and connect them with resources to help them be safer from suicide. These resources could include health care professionals, first responders, or crisis line workers—among many others who have suicide intervention training.

Training process

safeTALK features both presentations and interactive elements. Trainers will facilitate participants' involvement through:

- Trainer presentations
- Diverse selection of audiovisuals
- Interactive discussion and questions
- TALK steps practice
- TALK wallet card
- "You can TALK to Me" stickers

Goals and objectives

safeTALK helps participants become alert to suicide. Suicide-alert people are better prepared to connect persons with thoughts of suicide with life-affirming help. Over the course of their training, safeTALK participants will learn to:

- Notice and respond to situations where suicide thoughts may be present,
- Recognize that invitations for help are often overlooked,
- Move beyond the common tendency to miss, dismiss, and avoid suicide,
- Apply the TALK steps: Tell, Ask, Listen, KeepSafe, and
- Know community resources and how to connect someone with thoughts of suicide to them for further suicide-safer help.

> "As a taxi driver, I speak to a surprising number of people who have thoughts of suicide. **safeTALK has given me and other drivers in Kilkenny a way to help them stay safe.**"
>
> *—Derek Devoy, Taxi Driver, Kilkenny, Ireland*

safeTALK

ALERTNESS TRAINING

Who should take safeTALK?

safeTALK is designed for anyone age 15 or older, including many in more formal helping roles. The steps learned in safeTALK have helped participants from all walks of life be alert to situations where suicide thoughts may be present.

Who provides safeTALK?

safeTALK is a training developed by LivingWorks Education, a leading world provider of suicide intervention training. Each safeTALK is facilitated by a trainer who has completed the two-day safeTALK *Training for Trainers (T4T)* course. Trainers use internationally standardized learning materials, including a diverse selection of paired alert and non-alert vignettes.

A listing of registered trainers can be found at **www.livingworks.net** under **Find a Trainer.** In order to maintain registered status, trainers must deliver the workshop at least three times a year and submit quality control reports to LivingWorks.

safeTALK and ASIST

safeTALK is designed to complement *ASIST (Applied Suicide Intervention Skills Training),* LivingWorks' two-day suicide intervention skills workshop. safeTALK is consistent with LivingWorks' view that the training needs of a suicide-safer community require a comprehensive approach. Both safeTALK and ASIST participants have an important role to play in helping to achieve this goal.

safeTALK training focuses on using the *TALK* steps—*Tell, Ask, Listen, KeepSafe*—to engage persons with thoughts of suicide and help to connect them with life-affirming resources, while using ASIST skills helps these resources provide safety from suicide for now. In effect, safeTALK and ASIST-trained helpers work together with individuals to help them keep safe from suicide.

ASIST's intervention model involves establishing a collaborative relationship to work through suicide to a place of safety. Many training participants include safeTALK and ASIST in their suicide prevention toolkit.

11
countries have onsite Trainers

3,100+
safeTALK Trainers worldwide

490,000+
safeTALK participants trained since 2006

*Statistics current as of March, 2018

About LivingWorks: LivingWorks is dedicated to saving lives through the creation, development, and delivery of innovative training experiences that empower individuals, organizations, and communities to be safer from suicide. To learn more, visit **www.livingworks.net.**

LivingWorks | esuicideTALK | suicideTALK | safeTALK | ASIST | suicide to Hope

info@livingworks.net www.livingworks.net **TOLL FREE N.A.** 1.888.733.5484

Attachment H

TITLE OF TRAINING

safeTALK (suicide alertness for everyone – Tell, Ask, Listen, Keepsafe)

PROPOSED SCHEDULE

Please include dates, times and training session duration

safeTALK takes approximately 3.0 hours.

GEARED TO AND CAPACITY OF CLASS

Anyone within a community can take safeTALK. safeTALK is limited to 30 participants (with 1 trainer and 1 assistant).

TRAINING LEADER(S)

Please include title, credentials and affiliation

Each safeTALK Trainer has to be trained in suicide intervention and has attended a two day or a one day with extensive pre-study on-site safeTALK Training for Trainer class conducted by one of our LivingWorks certified instructors.

TRAINING DESCRIPTION

Summarize training objectives (what will participants be able to do upon completion) and methodology.

safeTALK teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. safeTALK stresses safety while challenging taboos that inhibit open talk about suicide. The safeTALK learning process is highly structured, providing graduated exposure to practice actions. The program is designed to help participants monitor the effect of false societal beliefs that can cause otherwise caring and helpful people to miss, dismiss, or avoid suicide alerts and to practice the TALK step actions to move past these three barriers. Six 60-90 second video scenarios, each with non-alert and alert clips, are selected from a library of scenarios and strategically used through the training to provide experiential referents for the participants.

Program Goals include:
1. Challenge attitudes that inhibit open talk about suicide.
2. Recognize a person who might be having thoughts of suicide.
3. Engage them in direct and open talk about suicide
4. Listen to the person's feelings about suicide and show that they are taken seriously.
5. Move quickly to connect them with someone trained in suicide intervention.

TRAINING AGENDA

List or attach the agenda for the training.

safeTALK is divided into two main sections, each with numerous sub-sections:

Time schedule for first section = 1.5 hours (ie: 9:00 am to 10:30 am)

1.1 Community Reasons for safeTALK
1.2 Personal Reasons for safeTALK
1.3 Introduction of safeTALK
1.4 Tell step
1.5 Ask step
1.6 Listen step
1.7 KeepSafe step
1.8 Conclusion/Summary of Part 1

Break (15 minutes) (ie: 10:30 am to 10:45 am)

Time schedule for second section = 1.5 hours (ie: 10:45 am to 12:15 pm)

2.1 Introduction of Part 2
2.2 Activate Your Willingness
2.3 The Importance of Being Nosey and Limits to the Suicide Alert Role
2.4 Preparing for Practice
2.5 Creating the Practice Scene
2.6 Practice
2.7 Close

AUDIO/VISUAL EQUIPMENT AND/OR SUPPLIES NEEDED

safeTALK incorporates training slides and videos which can be presented via PowerPoint using a computer and LCD projector, or using a DVD player and TV. The presentation can be customized for groups utilizing video clips from an extensive library.

Each safeTALK participant receives a 24-page Resource Book, a small prompter card, two safeTALK Stickers and a certificate. These participant kits are ordered by the safeTALK Trainer and distributed during the training.

safeTALK

suicide alertness for everyone

DATE LOCATION

TRAINER(S)

Your feedback is important—thank you. Please use the back of this form to note any additional comments.

1. My trainer was prepared and familiar with the material: O Strongly agree O Agree O Partly agree O Disagree
2. My trainer encouraged participation and respected all responses: O Strongly agree O Agree O Partly agree O Disagree
3. I intend to tell others that they will benefit from this training: O Yes O No

   My trainer can contact me for information about who to speak with to provide this training to others in my organization or community. My contact information is:

   _____

   _____

4. How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?
   O Well prepared O Mostly prepared O Partly prepared O Not prepared
5. On a scale of 1 (very bad) to 10 (very good), how would you rate this training? RATING
   Comments:

   _____

   _____

   _____

   _____

   _____

   _____

6. How could this training be improved to make it more effective in preparing suicide alert helpers?

   _____

   _____

   _____

   _____

   _____

   _____

7. My comments may be quoted anonymously to promote safeTALK: O Yes O No

If you would like to talk to your trainer further about your own or another's thoughts of suicide, please indicate your name and contact information:

safeTALK

suicide alertness for everyone

[Participant Name]

has completed training in suicide alertness

Date: [Date]
Location: [Location]
Hours: [Hours]

SIGNATURE

LivingWorks
suicide-safer communities · saving lives for tomorrow
www.livingworks.net

STATE OF NEVADA

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Bureau of Child, Family and Community Wellness
Office of Suicide Prevention
4150 Technology Way, Suite 101
Carson City, Nevada 89706
Telephone: (775) 684-2240 · Fax: (775) 684-8048

October 20, 2017

Nevada State Board of Pharmacy
431 West Plumb Lane
Reno, NV 89509

RE: Continuing Education Units for Gatekeeper 2 hour suicide prevention training

To Whom It May Concern:

Please find attached the Continuing Education Checklist Form and back up documents supporting Gatekeeper 2 hour suicide prevention training. Please note this training is modifiable to reflect updated data and supplemented to meet specific needs of various agencies. We request approval to allow your licensees to earn continuing education units for attending Gatekeeper 2.

The following trainers' resumes have been included in the packet for your review:

Allen, Misty
Egan, Richard
Massolo, Janett

Please do not hesitate to contact me is you need further information.
Thank you for your consideration.

Sincerely,

Angela Friedman
Administrative Assistant IV

CONTINUING EDUCATION CHECKLIST

Program Name: Gatekeeper 2 hour Training

Date of Program: Various dates and times throughout the year

Number of CE hours being requested 2.0 *accredited/acceptable (circle one)*

Name of Person Requesting Approval: Angela Friedman, Admin. Asst. IV

Contact Address: 4600 Kietzke Lane, B-114

Reno, NV 89502

Contact Phone#: 775-684-2240

Before the Continuing Education Committee for the Nevada State Board of Pharmacy gives approval, the board office must receive the following materials at least sixty (60) days before the program is presented.

X Copy of materials to be distributed to participants

X CV or equivalent information on presenter(s)

_____ Program syllabus or specifications/objectives of the program

_____ Statement certificate will be provided to participants

-or-

X Copy of certificate presented to participants

_____ Statement evaluation form will be provided to participants for the purpose of evaluating program materials

-or-

X Copy of evaluation form

If any information is missing everything will be returned.

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***FOLLOW-UP**: Within 60 days after the program, a list of pharmacist participants must be received at the board office. This list of pharmacists can be mailed prior to receiving notification of approval.*

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FOR OFFICE USE ONLY

_____ *Date Received by Board Office*

Course Content Outline

Title:	**Nevada Suicide Prevention Gatekeeper Training Workshop**
Purpose:	**Enhance understanding of suicide prevention and increase tools and resources for assistance to persons at risk for suicide**
Date:	**Various dates throughout 2017-2018**
Time:	**2 hours in length offered at various times**

Behavioral Objectives	Content Outline	Time Allotted	Instructor	Method of Presentation	Evaluation Method
At the conclusion of this session, the participant will be able to:				PowerPoint Presentation	
	Pre training survey Welcome and Introduction	10 minutes	Misty Allen Janett Massolo Rick Egan	Individual activity, lecture	Post test
A. Distinguish suicide myths from suicide facts.	Attitudes and beliefs	20 minutes	Misty Allen Janett Massolo Rick Egan	Small group activity, handout	Satisfaction evaluation
A. Identify suicide as a major public health problem that is preventable. B. Recognize that the incidence of non-fatal suicide attempts far outnumber incidence of completed suicides.	Overview of suicide prevalence in the U.S. and Nevada	10 minutes	Misty Allen Janett Massolo Rick Egan	Lecture	Post test

A. Identify signs and clues that increase risk of suicidal ideation and behaviors. B. Identify long-term risk factors and conditions that increase a person's risk of suicide. C. Describe internal and external factors to a person at risk that serve as protections against suicidal behaviors and help seeking attitudes.	Understanding persons in crisis ➢ Warning signs ➢ Risk factors ➢ Protective factors	25 minutes	Misty Allen Janett Massolo Rick Egan	Lecture, discussion	Satisfaction evaluation
A. Increase gatekeeper's confidence through simulated role play scenarios to directly ask about suicide ideation and behaviors. B. Demonstrate appropriate listening techniques. C. Briefly describe the phases and goal of a structured intervention: show you care, ask the question, connect to help.	Responding to suicidal ideation and behavior ➢ Asking about suicide ideation ➢ Goals of a suicide intervention ➢ Aspects of a structured intervention	25 minutes	Misty Allen Janett Massolo Rick Egan	Lecture, discussion, group activity	Post test
A. Identify local, state and national sources of information and appropriate professionals available as resources and referrals.	Community resources and case follow up post referral	5 minutes	Misty Allen Janett Massolo Rick Egan	Lecture and group discussion	Satisfaction evaluation

A. Define postvention activities. B. Clarify that postvention activities help to serve as support and prevention for bereaved survivors who are now at increased risk themselves.	Postvention Survivor support	5 minutes	Misty Allen Janett Massolo Rick Egan	Lecture and group discussion	Satisfaction evaluation
A. Share SPRC media guidelines for appropriate coverage of suicide in print, radio and television communication/ broadcasts.	Media guidelines	5 minutes	Misty Allen Janett Massolo Rick Egan	Lecture and handout	Satisfaction evaluation
A. Identify educational resources and training opportunities offered by the Nevada Office of Suicide Prevention	OSP resources and contact information	5 minutes	Misty Allen Janett Massolo Rick Egan	Lecture	Satisfaction evaluation
	Questions and closing	5 minutes	Misty Allen Janett Massolo Rick Egan	Question and answer	Satisfaction evaluation
	Post test/satisfaction evaluation	5 minutes		Individual activity	Post test
	Total Credit Hours	**2.0 hours**			

Certificate of Completion

Nevada Office of Suicide Prevention
Recognizes

Name

as having successfully completed the
Nevada Suicide Prevention Gatekeeper Training

This training program was presented by the staff of the Nevada Office of Suicide Prevention in conjunction with the Nevada Division for Child and Family Services in Las Vegas, NV.

Date: January 20th, 2011
2 hour Suicide Prevention Gatekeeper Program
License Number: #

Office of Suicide Prevention
Department of Health and Human Services

Misty Vaughan Allen

Trainer's Signature

Nevada Suicide Prevention Gatekeeper Training

POST TRAINING SURVEY

Today's Date _____ /_____/_____ Trainers: _____

Training was: Less than an hour 1 1/4 hours 2 hours 4 hours 8 hours
(Circle one)

After completing the Nevada Suicide Prevention Gatekeeper Training, what is your current knowledge about suicide prevention? (Circle one response per question.)
Please use the scale below to answer the following questions:

1. Not at all 2. Somewhat 3. To an average degree 4. Very 5. Extremely

1	What is your ability to recognize the clues (risk factors, warning signs, etc.) that may indicate a person is considering suicide?	1	2	3	4	5
2	How would you rate your level of knowledge about suicide intervention strategies?	1	2	3	4	5
3	How confident are you (at this moment) with your *ability* to intervene with a suicidal person?	1	2	3	4	5
4	How confident are you (at this moment) with your *willingness* to intervene with a suicidal person?	1	2	3	4	5
5	If you were concerned that a person was considering suicide, how likely would you be to ask that person directly if he/she were considering suicide?	1	2	3	4	5
6	To what degree do you think a family history of suicide is associated with a higher risk of suicide for the family?	1	2	3	4	5
7	How well informed are you with school, community, or professional resources to which individuals at risk of suicide can be referred for help?	1	2	3	4	5
8	Do you think suicide is attributable to one single cause?	1	2	3	4	5
9	How knowledgeable are you about the myths and facts regarding suicide?	1	2	3	4	5
10	How comfortable would you be talking to a family member of a recent suicide loss?	1	2	3	4	5
11	In general, how likely do you think an individual who has attempted suicide once would try again?	1	2	3	4	5
12	Has this entry level training increased your interest in attending more advanced suicide prevention training?	1	2	3	4	5

Please provide any suggestions or comments on today's training:_____

_____

_____

_____

14

15

16

Regulation Tracking Log

Regulation Number and Topic	Workshop Propose To Bd	30 Days To LCB W/Letter	LCB R0 Number Issued	LCB Return Date	30 Days Post Public Hearing	Public Hearing Meeting Date	To LCB Final W/ Cov./Info	Secretary of State File Date
					03/13/18 05/03/18	04/12/18 06/07/18		
639 PMP Registration/Access	01/11/18	01/12/18	R013-18	04/30/18	05/03/18	06/07/18	06/15/18	06/26/18
639 Show Cause	01/11/18	01/12/18	R014-18	02/27/18	03/13/18	04/12/18	04/17/18	05/16/18
639.742 Vet Dispensing 639.220 Schedule of Fees	01/11/18	01/12/18	R015-18	03/09/18	03/13/18	04/12/18	04/17/18	05/16/18
639.NEW Dispensing of CS in conformance with AB 474	03/07/18	03/13/18	R047-18	04/17/18 05/04/18	05/08/18	06/07/18	06/15/18	06/26/18
453.510 Schedule I – Adding New Substances (Fentanyl)	03/07/18	03/15/18	R048-18					
639.NEW (2) – Further defines CS prescribed for pain (AB474)	06/07/18	06/15/18	R144-18	07/17/18	07/27/18	09/05/18 12/05/18		
639.250 – Technician Ratio (Non-dispensing)	09/05/18 10/11/18 12/05/18	01/30/19	R002-19					
453.550 – Schedule V – Adding New Substance (Cannabiodiol)	12/05/18	12/26/18	R198-18	12/26/18	01/31/19	03/07/19	03/15/19	
453.520 – Schedule II – Dronabinol Oral Solution	01/17/19	01/30/19	R001-19					
639.NEW – FQHC Off-Site Dispensing	01/17/19	02/19/19	R004-19					
639.250 – Technician Ratio (Dispensing)	03/07/19 04/11/19 06/06/19							
639.NEW – Costs for Inspections	04/11/19	04/15/19	R005-19					
639.NEW – Transfer of new prescriptions.	06/06/19							

EXECUTIVE SECRETARY REPORT – June 5th, 2019

- **FINANCIAL REPORT**

- **TEMPORARY LICENSES**

- **STAFF ACTIVITIES**

    - Meetings with other health care boards
    - Nevada Department of Health and DEA regarding methadone clinics- Dave and Yenh
    - National NABP Meeting – Kevin, Jade, Melissa
    - Naloxone and Deterra bag – Yenh and Dave
    - Nevada Crisis Standards – Yenh
    - Grants – Yenh and Darla
    - Quarterly Crime Lab Meeting - Paul

- **REPORT TO BOARD**
    - Licensing software update
    - Grant employee Shannon Reichman

- **BOARD RELATED NEWS**
    - Legislative Update

- **ACTIVITIES REPORT**
    - PMP Integration
    - Inspection update
    - Online CE activity - Darla and Yenh

TEMPORARY LICENSES

(Issued since last board meeting)

Updated 5/21/2019

No temporary licenses were issued since the last board meeting.

17

17A

Proposed Regulation of the Nevada State Board of Pharmacy

Workshop

June 5, 2019

Explanation – Language in ***blue italics*** is new; language in ***red text*** [~~*omitted material*~~] is language to be omitted, and language in ***green text*** indicates prior Board-approved amendments that are in the process of being codified.

AUTHORITY: §1, NRS 639.070

A REGULATION relating to increasing the number of pharmaceutical technicians that a pharmacist may supervise; requiring personnel handling prescription drugs to be licensed by the Board; and providing other matters properly relating thereto.

Section 1. NAC 639.250 is hereby amended as follows: Except as otherwise provided in NAC 639.258:

1. Except as otherwise provided in this section, in a hospital,

(a) A pharmacist who is dispensing prescriptions may not supervise more than a total of ***eight*** ~~three~~ pharmaceutical technicians ***or pharmaceutical technicians in training*** at one time ***and no more than one of those persons may be a pharmaceutical technician in training.*** [~~A pharmacist who is supervising distributive functions may not supervise more than a total of *four* [two] pharmaceutical technicians and one pharmaceutical technician in training while the trainee is performing technician functions in on-the-job training.~~]

(b) When there are two or more pharmacists on duty, a pharmacist who is performing non-chart order dispensing may not supervise more than one pharmaceutical technician or pharmaceutical technician in training. That pharmacist's presence in the facility cannot be included in calculating the ratio described in subsection 1(a) above.

2. Except as otherwise provided in this section, in any pharmacy, other than a hospital pharmacy, a pharmacist may not supervise more than a total of ***eight*** [~~three~~] pharmaceutical technicians or ***five*** [~~one~~] pharmaceutical ***technicians*** [~~technician~~] and ***three*** [~~two~~] pharmaceutical technicians in training at one time.

3. In any telepharmacy, remote site or satellite consultation site, a pharmacist may not supervise more than a total of three pharmaceutical technicians at one time.

[~~4. A pharmacist may supervise more pharmaceutical technicians and pharmaceutical technicians in training at one time than are otherwise allowed pursuant to subsections 1 and 2 if:~~

~~(a) Not more than three of the pharmaceutical technicians or pharmaceutical technicians in training are performing the duties of a pharmaceutical technician as set forth in NAC 639.245; and~~

~~(b) The record kept by the pharmacy pursuant to NAC 639.245 identifies the pharmaceutical technicians and pharmaceutical technicians in training who are performing the duties of a pharmaceutical technician as set forth in NAC 639.245.]~~

4. Except as otherwise provided in NAC 639.520(4), no person may perform any task in a pharmacy where they come into contact with any prescription drug that is not packaged for final sale and verified by a pharmacist unless that person is registered with the Board as a pharmacist, intern pharmacist, pharmaceutical technician or pharmaceutical technician in training.

5. Subject to the limitations above, the determination of the appropriate pharmacist to pharmaceutical technician ratio in the pharmacy at any time shall be made by the pharmacy's managing pharmacist or pharmacist in charge. No other person, registrant or licensee shall interfere with the exercise of the managing pharmacist or pharmacist in charge's independent professional judgment as to staffing and pharmacist to pharmaceutical technician ratios for that pharmacy.

Sec. 2. NAC 639.701 is hereby repealed. ~~The following acts are not required to be performed by a pharmacist, intern pharmacist, pharmaceutical technician or pharmaceutical technician in training:~~

~~1. Entering information into the pharmacy's computer other than information contained in a new prescription concerning the prescription drug and the directions for its use.~~

~~2. Processing sales, including the operation of a cash register.~~

~~3. Stocking shelves.]~~

~~4. Delivering medication to a patient or to areas of a hospital where patients are cared for.]~~

17B

Documentation for this agenda item will be provided at a later date.

18

19