

NEVADA STATE BOARD OF PHARMACY
 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
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.

<input type="checkbox"/> New Pharmacy	<input checked="" type="checkbox"/> Ownership Change (Please provide current license number if making changes: PH 03238)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input type="checkbox"/> Partnership - Pages 1,2,5,7
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7

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

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Animal Health International, Inc
 Physical Address: 203 Fourth Avenue West, Twin Falls, ID 83301-6313
 Mailing Address: Attn: Marcus Prochazka, 822 7th St., Ste. 700 Greeley CO 80631
 City: Twin Falls State: ID Zip Code: 83301
 Telephone: 970-584-5284 Fax: 970-347-3822
 Toll Free Number: 1-800-792-1228 (Required per NAC 639.708)
 E-mail: Marcus.Prochazka@animalhealthinternational.com Website: http://www.animalhealthinternational.com
 Managing Pharmacist: Eric Andersen License Number: P5504

<u>TYPE OF PHARMACY</u>	<u>AND</u>	<u>SERVICES PROVIDED</u>
Yes/No		Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear		<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input type="checkbox"/> <input checked="" type="checkbox"/> Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
		<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

All boxes must be checked
 For the application to be complete

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

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New Pharmacy or **Ownership Change** (Provide current license number if making changes: **PH 02131**)
 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: Biologics, Inc.
 Physical Address: 120 Weston Oaks Court
 Mailing Address: Same as above.
 City: Cary State: NC Zip Code: 27513-2256
 Telephone: 919-546-9810 Fax: 919-831-0440
 Toll Free Number: 800-850-4306 (Required per NAC 639.708)
 E-mail: info@biologicsinc.com Website: www.biologicsinc.com
 Managing Pharmacist: Gregory Wolfe License Number: NC - 20400

TYPE OF PHARMACY AND SERVICES PROVIDED

<p>Yes/No</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Retail</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Internet</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Community</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____</p> <p>All boxes must be checked For the application to be complete</p>	<p>Yes/No</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____</p>
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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: BRAUN PHARMA INC.

Physical Address: 2060 N. CLARK ST. CHICAGO IL 60614

Mailing Address: 2060 N. CLARK ST. CHICAGO, IL 60614

City: CHICAGO State: IL Zip Code: 60614

Telephone: 773.549.0634 Fax: 773.549.2753

Toll Free Number: 877.549.6907 (Required per NAC 639.708)

E-mail: STEVE@BRAUNRX.COM Website: WWW.BRAUNRX.COM

Managing Pharmacist: SHARROD SEYMORE License Number: 051.289557

TYPE OF PHARMACY AND	SERVICES PROVIDED
Yes/No	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail	<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear	<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center	<input checked="" type="checkbox"/> Mail Service
<input type="checkbox"/> <input checked="" type="checkbox"/> Community	<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____	<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
All boxes in this section must be checked for the application to be complete	<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
	<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
	<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

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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: Byram Healthcare Centers, Inc.

Physical Address: 3793 S. State Street

Mailing Address: 3793 S. State Street

City: Salt Lake City State: Utah Zip Code: 84115

Telephone: 801-716-8796 Fax: 801-268-9709

Toll Free Number: 800-775-4372 (Required per NAC 639.708)

E-mail: souellette@byramhealthcare.com Website: www.byramhealthcare.com

Managing Pharmacist: Elaine Ripplinger License Number: 6940723-1701

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No

- Retail
 Hospital (# beds _____)
 Internet
 Nuclear
 Ambulatory Surgery Center
 Community
 Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
 Parenteral **
 Parenteral (outpatient)
 Outpatient/Discharge
 Mail Service
 Long Term Care
 Sterile Compounding **
 Non Sterile Compounding
 Mail Service Sterile Compounding **
 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,**

92004

NEVADA STATE BOARD OF PHARMACY

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New Pharmacy or Ownership Change (Provide current license number if making changes: PH 03418)
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: CZ Services, Inc. DBA CareZone Pharmacy

Physical Address: 860 Harbour Way South, Suite E

Mailing Address: Same as above.

City: Richmond State: CA Zip Code: 94804-3648

Telephone: (844) 792-2739 Fax: (844) 708-0120

Toll Free Number: (844) 792-2739 (Required per NAC 639.708)

E-mail: pharmacists@carezone.com Website: http://czpharmacy.com

Managing Pharmacist: Nicolas Terranova License Number: RPH 72264 (CA)

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: compliance
packaging

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

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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: DaVita Rx, LLC

Physical Address: 485 N. Juniper Dr., Chandler, AZ 85226

Mailing Address: 1111 Bayhill Dr. #285

City: San Bruno State: CA Zip Code: 94066

Telephone: 901-867-5357 Fax: 866-208-4462

Toll Free Number: 888-817-8482 (Required per NAC 639.708)

E-mail: mark.carlson@davita.com Website: www.davitarx.com

Managing Pharmacist: Mark Carlson License Number: S021321

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services**
- Parenteral ****
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding ****
- Non Sterile Compounding
- Mail Service Sterile Compounding ****
- 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,**

92099

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Application type and ownership options: New Pharmacy or Ownership Change, Publicly Traded Corporation, Non Publicly Traded Corporation, Partnership, Sole Owner.

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Hillmoor Pharmacy

Physical Address: 1401 SE Goldtree Drive

Mailing Address:

City: Port Saint Lucie State: FL Zip Code: 34952

Telephone: 772 237 4426 Fax: 772 237 4482

Toll Free Number: 888 278 0076 (Required per NAC 639.708)

E-mail: hillmoorpharmacy@gmail.com Website:

Managing Pharmacist: Paul Rohrbaugh License Number: PS19253

TYPE OF PHARMACY AND SERVICES PROVIDED

Checkboxes for pharmacy types (Retail, Hospital, Internet, Nuclear, Ambulatory Surgery Center, Community, Other) and services (Off-site Cognitive Services, Parenteral, Outpatient/Discharge, Mail Service, Long Term Care, Sterile Compounding, Non Sterile Compounding, Mail Service Sterile Compounding, 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,

92239

NEVADA STATE BOARD OF PHARMACY
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<input checked="" type="checkbox"/> New Pharmacy (Please provide current license number if making changes: PH _____)	<input type="checkbox"/> Ownership Change
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input type="checkbox"/> Partnership - Pages 1,2,5,7
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Home Towne Rx (store #1)

Physical Address: 1400 Parkway Ave

Mailing Address: SAME

City: Ewing State: NJ Zip Code: 08628

Telephone: (609) 323-7503 Fax: (609) 323-7508

Toll Free Number: 844-448-7320 (Required per NAC 639.708)

E-mail: _____ Website: _____

Managing Pharmacist: Mitra Borkhani License Number: 28RI 02729200

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail	<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear	<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center	<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input type="checkbox"/> <input checked="" type="checkbox"/> Community	<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____	<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
	<input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding
	<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
	<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

All boxes must be checked
 For the application to be complete

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

92097

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(LLC)

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: PharmaMedRx LLC; DBA: "Mint Pharmacy and Skin Clinic"

Physical Address: 1201 US Hwy 1, Ste. 1, North Palm Beach, FL 33408

Mailing Address: 1201 US Hwy 1, Ste. 1

City: North Palm Beach State: FL Zip Code: 33408

Telephone: 866-855-6468 Fax: 561-619-5169

Toll Free Number: 866-855-6468 (Required per NAC 639.708)

E-mail: info@mintrxpharmacy.com Website: mintrxpharmacy.com (informational website)

Managing Pharmacist: Jennifer Mooney-Thompson License Number: PS39128

TYPE OF PHARMACY AND SERVICES PROVIDED

<p>Yes/No</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Retail</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Internet</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Community</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p> <p style="color: red;">All boxes must be checked For the application to be complete</p>	<p>Yes/No</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Non Sterile Compounding</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Services: _____</p>
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****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

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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: Pharmacare Plus

Physical Address: 6720 Sands Point Dr. Suite 105

Mailing Address: 6720 Sands Point Dr. Suite 105

City: Houston State: Tx. Zip Code: 77074

Telephone: (832) 269-5348 Fax: (888) 7858-6894

Toll Free Number: 1844-236-9713 (Required per NAC 639.708)

E-mail: july.tech.tc@gmail.com Website: _____

Managing Pharmacist: Nikki Denson License Number: 38953

TYPE OF PHARMACY AND SERVICES PROVIDED

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

92233

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Application form header with checkboxes for ownership types: New Pharmacy, Ownership Change, Publicly Traded Corporation, Non Publicly Traded Corporation, Partnership, Sole Owner. Includes handwritten license number PH 63204.

GENERAL INFORMATION to be completed by all types of ownership

General information fields: Pharmacy Name (PRAXIS Rx PHARMACY), Physical Address (5455 W WATERS AVE, STE 214 TAMPA, FL 33634), Mailing Address (103 W. VANDALZA ST. STE 100 EDWARDSVILLE IL 62025), Telephone (888-903-7453), Fax (888-958-2831), Toll Free Number (888-903-7453), E-mail (BRATLEY@PRAXISRX.COM), Website (WWW.PRAXISRX.COM), Managing Pharmacist (WILLIAM S. BAILEY), License Number (19639).

TYPE OF PHARMACY AND SERVICES PROVIDED

Service selection table with two columns: TYPE OF PHARMACY and SERVICES PROVIDED. Includes checkboxes for Retail, Hospital, Internet, Nuclear, Ambulatory Surgery Center, Community, Other, Off-site Cognitive Services, Parenteral, Outpatient/Discharge, Mail Service, Long Term Care, Sterile Compounding, Non Sterile Compounding, Mail Service Sterile Compounding, and 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.

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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: Solera Specialty Pharmacy

Physical Address: 2100 Park Central Blvd N, STE 300, Pompano Beach, FL 33064

Mailing Address: 2100 Park Central Blvd N, STE 300

City: Pompano Beach State: FL Zip Code: 33064

Telephone: 877-712-7864 Fax: 877-712-7866

Toll Free Number: 877-712-7864 (Required per NAC 639.708)

E-mail: pharmacy@solerarx.com Website: www.SoleraRx.com

Managing Pharmacist: John Hamann License Number: FL PS30582

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked

For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- 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.

92234

NEVADA STATE BOARD OF PHARMACY
 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
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.

<input checked="" type="checkbox"/> New Pharmacy (Please provide current license number if making changes: PH _____)	<input type="checkbox"/> Ownership Change
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7 <input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input checked="" type="checkbox"/> Partnership - Pages 1,2,5,7 <input type="checkbox"/> Sole Owner – Pages 1,2,6,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Accurate Rx Pharmacy Consulting, LLC
 Physical Address: 103-B Corporate Lake Drive
 Mailing Address: 103-B Corporate Lake Drive
 City: Columbia State: MO Zip Code: 65203
 Telephone: 573-256-4279 Fax: 573-442-6429
 Toll Free Number: 1-888-335-4279 (Required per NAC 639.708)
 E-mail: info@accuraterx.net Website: www.accuraterx.net
 Managing Pharmacist: Jay Bryant-Wimp License Number: 431165

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail	<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet	<input checked="" type="checkbox"/> <input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear	<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center	<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input type="checkbox"/> <input checked="" type="checkbox"/> Community	<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____	<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
	<input checked="" type="checkbox"/> <input type="checkbox"/> Non Sterile Compounding
	<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
	<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

All boxes must be checked
 For the application to be complete

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

92101

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 02651)
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: Geneva Woods Pharmacy

Physical Address: 2818 North Sullivan RD. Bldg. 2E

Mailing Address: SAME

City: Spokane Valley State: WA Zip Code: 99216

Telephone: 509-744-9891 Fax: 509-742-3494

Toll Free Number: 800-713-4189 (Required per NAC 639.708)

E-mail: carmen.berg@genevawoods.com Website: www.genevawoods.com

Managing Pharmacist: Carmen Berg License Number: PH02651

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: Long Term Care

All boxes must be checked

For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: Mail Service Non Sterile Compounding

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

5A9163

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: G&K Pharmacy DBA Glades Drugs

Physical Address: 4680 Broadway, Aikentown, PA 18104

Mailing Address: 1095 Broken Sound Parkway NW, suite 300

City: Boca Raton State: FL Zip Code: 33487

Telephone: 610-351-2666 Fax: 610-351-2662

Toll Free Number: 844-452-3371 (Required per NAC 639.708)

E-mail: info@gladesdrugs.com Website: www.gandkpharmacy.com

Managing Pharmacist: Heather Stanton License Number: RP032537L

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- 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,**

92098

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.

<input checked="" type="checkbox"/> New Pharmacy or <input type="checkbox"/> Ownership Change (Provide current license number if making changes: PH _____)	
Check box below for type of ownership and complete all required forms.	
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input type="checkbox"/> Partnership - Pages 1,2,5,7
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Phusion Pharmacy

Physical Address: 17 Coventry Shoppers Park

Mailing Address: _____

City: Coventry State: RI Zip Code: 02816

Telephone: 401-823-0000 Fax: 401-823-0300

Toll Free Number: 855-748-7466 (Required per NAC 639.708)

E-mail: hughes.david@phusionrx.com Website: www.phusionrx.com

Managing Pharmacist: Brian Cardarelli License Number: RPH03997

TYPE OF PHARMACY AND SERVICES PROVIDED

es/No	AND	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Infonet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear		<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input checked="" type="checkbox"/> <input type="checkbox"/> Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
		<input checked="" type="checkbox"/> <input type="checkbox"/> Non Sterile Compounding
		<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
		<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

All boxes must be checked
 For the application to be complete

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

91856

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: PH⁰³¹⁴⁹ 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: Pinnacle Compounding

Physical Address: 1120 Kensington Ave Suite E Missoula, MT 59801

Mailing Address: PO Box 1615

City: Missoula State: MT Zip Code: 59806

Telephone: 406-541-6121 Fax: 406-541-6267

Toll Free Number: 1-855-466-1076 (Required per NAC 639.708)

E-mail: info@pinnaclecompounds.com Website: www.pinnaclecompounds.com

Managing Pharmacist: Amy Frost License Number: MT 5245

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No

- ☑ ☐ Retail
☐ ☑ Hospital (# beds ___)
☐ ☑ Internet
☐ ☑ Nuclear
☐ ☑ Ambulatory Surgery Center
☑ ☐ Community
☐ ☑ Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- ☐ ☑ Off-site Cognitive Services
☐ ☑ Parenteral **
☐ ☑ Parenteral (outpatient)
☐ ☑ Outpatient/Discharge
☑ ☐ Mail Service
☐ ☑ Long Term Care
☐ ☑ Sterile Compounding **
☑ ☐ Non Sterile Compounding
☐ ☑ Mail Service Sterile Compounding **
☐ ☑ 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

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: RSVP PHARMACY #7

Physical Address: 4300 SUGAR RD, STE 400, FARMERS BRANCH, TX 75244

Mailing Address: SAME AS ABOVE

City: FARMERS BRANCH State: TX Zip Code: 75244

Telephone: 855-313-7049 Fax: 855-261-1501

Toll Free Number: 855-313-7049 (Required per NAC 639.708)

E-mail: ACASTLEMAN@RSVPRX.COM Website: N/A

Managing Pharmacist: RYAN ELROD License Number: 46733

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/> Retail	<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> <input checked="" type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **
<input type="checkbox"/> <input checked="" type="checkbox"/> Internet	<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> <input checked="" type="checkbox"/> Nuclear	<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> <input checked="" type="checkbox"/> Ambulatory Surgery Center	<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service
<input checked="" type="checkbox"/> <input type="checkbox"/> Community	<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care
<input type="checkbox"/> <input checked="" type="checkbox"/> Other: _____	<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **
	<input checked="" type="checkbox"/> <input type="checkbox"/> Non Sterile Compounding
	<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **
	<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____

All boxes must be checked
For the application to be complete

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

91858

NEVADA STATE BOARD OF PHARMACY
 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
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.

<input checked="" type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: PH _____)	
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input checked="" type="checkbox"/> Partnership - Pages 1,2,5,7
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: RSVP RX #100, LLC

Physical Address: 7904 NE LOOP 820, Ste A&B, North Richland Hills, TX 76180

Mailing Address: 6200 Bridge Point Pkwy, Bldg 3 Ste 200

City: Austin State: TX Zip Code: 78730

Telephone: 855-362-7878 Fax: 855-833-4990

Toll Free Number: 855-362-7878 (Required per NAC 639.708)

E-mail: mkurtz2@rsvprx.com Website: N/A

Managing Pharmacist: Melissa Kurtz License Number: 46179

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

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

91933

NEVADA STATE BOARD OF PHARMACY
 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
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.

<input checked="" type="checkbox"/> New Pharmacy (Please provide current license number if making changes: PH _____)	<input type="checkbox"/> Ownership Change
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input checked="" type="checkbox"/> Partnership - Pages 1,2,5,7
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: RSVP Pharmacy #7, LLC DBA: RSVP RX #701

Physical Address: 5004 Frankford Ave, Suite 119 LUBBOCK TX 79424

Mailing Address: 6300 Bridgepoint Pkwy Bldg 3 Ste 200

City: Austin State: TX Zip Code: 78730

Telephone: 844-369-9209 Fax: 844-369-9210

Toll Free Number: 844-369-9209 (Required per NAC 639.708)

E-mail: ucastleman@shcacs.com Website: _____

Managing Pharmacist: Amberly Hix License Number: 48637

TYPE OF PHARMACY AND SERVICES PROVIDED

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

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

92003

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: Specialty Chemist Corp.
 Physical Address: 65-60 Fresh Meadows Lane, Fresh Meadows, NY 11365
 Mailing Address: 65-60 Fresh Meadows Lane
 City: Fresh Meadows State: NY Zip Code: 11365
 Telephone: 718-353-2595 Fax: 718-886-8658
 Toll Free Number: 844-424-3647 (Required per NAC 639.708)
 E-mail: shahbraz.chaudhary@gmail.com Website: www.specialtychemist.com
 Managing Pharmacist: SOPHIA CHAUDHARY License Number: 061430-1

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	AND	SERVICES PROVIDED	Yes/No
<input checked="" type="checkbox"/> <input type="checkbox"/>	Retail		<input type="checkbox"/> <input checked="" type="checkbox"/> Off-site Cognitive Services	<input type="checkbox"/> <input checked="" type="checkbox"/>
<input type="checkbox"/> <input checked="" type="checkbox"/>	Hospital (# beds _____)		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral **	<input type="checkbox"/> <input checked="" type="checkbox"/>
<input type="checkbox"/> <input checked="" type="checkbox"/>	Internet		<input type="checkbox"/> <input checked="" type="checkbox"/> Parenteral (outpatient)	<input type="checkbox"/> <input checked="" type="checkbox"/>
<input type="checkbox"/> <input checked="" type="checkbox"/>	Nuclear		<input type="checkbox"/> <input checked="" type="checkbox"/> Outpatient/Discharge	<input checked="" type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input checked="" type="checkbox"/>	Ambulatory Surgery Center		<input checked="" type="checkbox"/> <input type="checkbox"/> Mail Service	<input type="checkbox"/> <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> <input type="checkbox"/>	Community		<input type="checkbox"/> <input checked="" type="checkbox"/> Long Term Care	<input type="checkbox"/> <input checked="" type="checkbox"/>
<input type="checkbox"/> <input checked="" type="checkbox"/>	Other: _____		<input type="checkbox"/> <input checked="" type="checkbox"/> Sterile Compounding **	<input checked="" type="checkbox"/> <input type="checkbox"/>
			<input checked="" type="checkbox"/> <input type="checkbox"/> Non Sterile Compounding	<input type="checkbox"/> <input checked="" type="checkbox"/>
			<input type="checkbox"/> <input checked="" type="checkbox"/> Mail Service Sterile Compounding **	<input type="checkbox"/> <input checked="" type="checkbox"/>
			<input type="checkbox"/> <input checked="" type="checkbox"/> Other Services: _____	

All boxes must be checked
For the application to be complete

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

92242

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: Tailstorm Health, LLC , dba Valley of the Sun Pharmacy

Physical Address: 15600 N. Black Canyon Highway, Suite B135

Mailing Address: 15600 N. Black Canyon Highway, Suite B135

City: Phoenix State: Arizona Zip Code: 85053

Telephone: 602-896-0454 Fax: 602-896-0456

Toll Free Number: 844-622-5045 (Required per NAC 639.708)

E-mail: hartley@vosrx.com Website: www.valleyofthesunpharmacy.com

Managing Pharmacist: Valerie Coronado License Number: S016234

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- Retail
- Hospital (# beds _____)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: _____

All boxes must be checked
For the application to be complete

Yes/No

- Off-site Cognitive Services
- Parenteral **
- Parenteral (outpatient)
- Outpatient/Discharge
- Mail Service
- Long Term Care
- Sterile Compounding **
- Non Sterile Compounding
- Mail Service Sterile Compounding **
- Other Services: Specialty

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

91899

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.

<input type="checkbox"/> New Wholesaler	<input checked="" type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_01639)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Animal Health International, Inc

Physical Address: 8711 West Doe Avenue

Mailing Address: Attn: Marcus Prochazka, 822 7th St., Ste. 700, Greeley, CO 80631

City: Visalia State: CA Zip Code: 93291

Telephone: (559) 635-3800 Fax: (970) 584-5814

Toll Free Number: N/A

E-mail: Marcus.Prochazka@animalhealthinternational.com Website: http://www.animalhealthinternational.com

Facility Manager: Richard Sheets

Professional qualifications and experience of facility manager: Daily operation of wholesale drug dist.
including receiving, putting away stock, rotation of stock, picking orders, shipping orders and tracing shipments. Experience complying
and following all mandated rules form entities such as FDA, DEA, EPA, DOT, local and state agencies etc.

Types of licensed outlets or authorized persons firm will serve:

<input type="checkbox"/> Pharmacies	<input type="checkbox"/> Practitioners	<input type="checkbox"/> Hospitals	<input checked="" type="checkbox"/> Wholesalers
<input checked="" type="checkbox"/> Other: <u>Veterinarians</u>			

Type of Products to be handled or wholesaled be firm:

<input checked="" type="checkbox"/> Legend Pharmaceuticals, Supplies or Devices	<input type="checkbox"/> Hypodermic Devices
<input type="checkbox"/> Poisons or Chemicals	<input checked="" type="checkbox"/> Veterinary Legend Drugs
<input checked="" type="checkbox"/> Controlled Substances (include copy of DEA)	
<input type="checkbox"/> Other: _____	

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Becton, Dickinson and Company

Physical Address: 26 Loveton Circle, Sparks, MD 21152

Mailing Address: 26 Loveton Circle

City: Sparks State: MD Zip Code: 21152

Telephone: 410-316-3800 Fax: 410-316-3830

Toll Free Number: N/A

E-mail: Jackie_A_Schwartz@bd.com Website: www.bd.com

Facility Manager: Jacquelyn A. Schwartz

Professional qualifications and experience of facility manager: See Attachment B

Types of licensed outlets or authorized persons firm will serve:

- Pharmacies Practitioners Hospitals Wholesalers
 Other: Clinics, Distributors, and Nursing Home Pharmacies.

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)
 Other: _____

manu

91931

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation	<input type="checkbox"/> Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation	<input type="checkbox"/> Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner ☐ Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.		

GENERAL INFORMATION

Facility Name: Corcept Therapeutics Incorporated

Physical Address: 149 Commonwealth Drive

Mailing Address: _____

City: Menlo Park State: CA Zip Code: 94025

Telephone: 650-327-3270 Fax: 650-327-3218

Toll Free Number: n/a

E-mail: statelicensing@corcept.com Website: www.corcept.com

Facility Manager: David Penake

Professional qualifications and experience of facility manager: See Attached

Types of licensed outlets or authorized persons firm will serve:

- Pharmacies Practitioners Hospitals Wholesalers
 Other: Specialty Pharmacy & Distribution

Type of Products to be handled or wholesaled by firm:

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

manu

91963

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

*** Limited Liability Company ***

GENERAL INFORMATION

Facility Name: DPT Lakewood, LLC

Physical Address: 1200 Paco Way, Lakewood, NJ 08701

Mailing Address: State License Servicing, Inc., 1751 State Route 17A, Ste 3

City: Florida State: NY Zip Code: 10921

Telephone: 732-367-9000 Fax: 732-730-3392

Toll Free Number: 866-225-5378

E-mail: DPT@slny.com Website: www.dptlabs.com

Facility Manager: Eugene F. Ciolfi

Professional qualifications and experience of facility manager: Manager with DPT for 15 years and another 10 years previously at Bauch and Lomb.

Types of licensed outlets or authorized persons firm will serve:

Pharmacies Practitioners Hospitals Wholesalers
 Other: Own Label Manufacturers

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)
 Other: _____

92243

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.

<input checked="" type="checkbox"/> New Wholesaler (3PL) <input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH_____)

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4 <input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b <input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: DSC Logistics, Inc.

Physical Address: 874 Thomas Parkway, Jefferson, GA 30549

Mailing Address: 1750 S. Wolf Rd. / Attn.: Sue Winter

City: Des Plaines State: IL Zip Code: 60018

Telephone: (706) 708-3005 Fax: (706) 367-1074

Toll Free Number: N/A

E-mail: susan.winter@dsclogistics.com Website: www.dsclogistics.com

Facility Manager: Ryan Aberg (Facility Mgr. & Designated Representative)

Professional qualifications and experience of facility manager: Ryan has previously held the Logistics Mgr. & Designated Rep title at DSC's Rancho Cucamonga, CA facility and was recently moved to head operations at this new facility. He is a licensed DR and 3PL DR.
Types of licensed outlets or authorized persons firm will serve:

Pharmacies Practitioners Hospitals Wholesalers
 Other: Acute Care Centers

Type of Products to be handled or wholesaled by firm:

Legend Pharmaceuticals, Supplies or Devices Hypodermic Devices
 Poisons or Chemicals Veterinary Legend Drugs
 Controlled Substances (include copy of DEA)
 Other: Non-Rx Medical Devices

92005

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: GenPak Solutions, LLC d/b/a EthIPak

Physical Address: 4324 Reynolds Drive, Hilliard, Oh 43026

Mailing Address: same

City: _____ State: _____ Zip Code: _____

Telephone: 614-319-3749 Fax: 614-319-4728

Toll Free Number: N/A

E-mail: todd@genpak.net Website: genpak.net

Facility Manager: Todd Paul, President

Professional qualifications and experience of facility manager: Resume attached

Types of licensed outlets or authorized persons firm will serve:

<input checked="" type="checkbox"/> Pharmacies	<input type="checkbox"/> Practitioners	<input type="checkbox"/> Hospitals	<input type="checkbox"/> Wholesalers
<input type="checkbox"/> Other: _____			

Type of Products to be handled or wholesaled be firm:

<input checked="" type="checkbox"/> Legend Pharmaceuticals, Supplies or Devices	<input type="checkbox"/> Hypodermic Devices
<input type="checkbox"/> Poisons or Chemicals	<input type="checkbox"/> Veterinary Legend Drugs
<input type="checkbox"/> Controlled Substances (include copy of DEA)	
<input type="checkbox"/> Other: _____	

92230

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation	<input type="checkbox"/> Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation	<input type="checkbox"/> Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner ☐ Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.		

GENERAL INFORMATION

Facility Name: Halozyme Therapeutics Inc.

Physical Address: 11388 Sorrento Valley Rd

Mailing Address: 11388 Sorrento Valley Rd

City: San Diego State: CA Zip Code: 92121

Telephone: 858-794-8889 Fax: 858-704-8300

Toll Free Number: n/a

E-mail: info@halozyme.com Website: http://www.halozyme.com

Facility Manager: Laurie Stelzer

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 Hypodermic Devices
 Poisons or Chemicals Veterinary Legend Drugs
 Controlled Substances (include copy of DEA)
 Other: _____

92228

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.

<input checked="" type="checkbox"/> New Wholesaler <input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH_____)

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4 <input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b <input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: Heritage Pharmaceuticals Inc.

Physical Address: 12 Christopher Way, Suite 300, Eatontown, NJ 07724

Mailing Address: 12 Christopher Way, Suite 300

City: Eatontown State: NJ Zip Code: 07724

Telephone: (732) 429-1000 Fax: (732) 429-1001

Toll Free Number: _____

E-mail: mryan@heritagepharma.com Website: www.heritagepharma.com

Facility Manager: Jeffrey Glazer

Professional qualifications and experience of facility manager: See Attached

Types of licensed outlets or authorized persons firm will serve:

Pharmacies Practitioners Hospitals Wholesalers
 Other: Retailers

Type of Products to be handled or wholesaled by firm:

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

92229

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.

<input checked="" type="checkbox"/> New Wholesaler <input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH_____)

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4 <input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b <input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: Medline Industries, Inc.

Physical Address: 1960 W Miro Way, Rialto, CA 92376

Mailing Address: One Medline Place

City: Mundelein State: IL Zip Code: 60060

Telephone: 847-643-3803 Fax: 866-780-9777

Toll Free Number: 800-633-5463

E-mail: mjortiz@medline.com Website: www.medline.com

Facility Manager: Manuel Delgado

Professional qualifications and experience of facility manager: Over 11 years of Drug Distribution experience
I oversee the facility and am involved with ensuring the accuracy of all transactions, procedures, policies,
record keeping and inventory. See Attachment 3

Types of licensed outlets or authorized persons firm will serve:

Pharmacies Practitioners Hospitals Wholesalers
 Other: Nursing Homes, Surgery Centers, Long term Care

Type of Products to be handled or wholesaled by firm:

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

92006

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Medline Industries, Inc.

Physical Address: 5701 Promontory Parkway Suite 100 Tracy, CA 95377

Mailing Address: One Medline Place

City: Mundelein State: IL Zip Code: 60060

Telephone: pending installation Fax: pending installation

Toll Free Number: 1-800-medline

E-mail: mleonard@medline.com Website: www.medline.com

Facility Manager: Scott Saling

Professional qualifications and experience of facility manager: Please see attachment #2.

Types of licensed outlets or authorized persons firm will serve:

Pharmacies Practitioners Hospitals Wholesalers

Other: Nursing Homes, Surgery Centers, Long Term Care

Type of Products to be handled or wholesaled by firm:

Legend Pharmaceuticals, Supplies or Devices Hypodermic Devices

Poisons or Chemicals Veterinary Legend Drugs

Controlled Substances (include copy of DEA)

Other: Cosmetics

92103

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Merit Medical Systems, Inc.

Physical Address: 1600 W Merit Parkway

Mailing Address: 1600 W Merit Parkway

City: South Jordan State: UT Zip Code: 84095

Telephone: 801-253-1600 Fax: 801-253-1652

Toll Free Number: _____

E-mail: gina.peterson@merit.com Website: www.merit.com

Facility Manager: Ron Frost

Professional qualifications and experience of facility manager: Current Merit COO, previously Quality Engineer
a Manufacturing Engineer, Custom Kits Manager, Customer Service Manager, Production Planning, and Warehouse 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 Hypodermic Devices
 Poisons or Chemicals Veterinary Legend Drugs
 Controlled Substances (include copy of DEA)
 Other: _____

92226

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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH _____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Paragon Enterprises, Inc.

Physical Address: 3300 Corporate Ave, Suite 114

Mailing Address: Same as Above

City: Weston State: FL Zip Code: 33331

Telephone: (954) 389-1700 Fax: (954) 510-2318

Toll Free Number: (800) 758-2955

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

Facility Manager: Rudy M. LaVecchia

Professional qualifications and experience of facility manager: 20+ years of Pharmaceutical experience, Complaine, Record Keeping, Oversees Daily Operations, Inventory Management.

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)
 Other: _____

92231

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 Ownership Change
(Please provide current license number if making changes: WH _____)

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

Facility Name: Praxair Distribution, Inc.

Physical Address: 1930 Loveridge Road, Pittsburg, CA 94565

Mailing Address: 2301 SE Creekview Drive Attn: Barbara Kasting

City: Ankeny State: IA Zip Code: 50021

Telephone: 925-252-2901 Fax: 925-427-9790

Toll Free Number: 800-772-9247

E-mail: jemal_norwood@praxair.com Website: www.praxair.com

Facility Manager: Jemal Norwood

Professional qualifications and experience of facility manager: Sr. Plant Manager with 20 years in the gas industry and 15 years of management experience.

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)
 Other: Medical Gases/Mixtures

manu

91852



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.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH _____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Primary Pharmaceuticals, Inc

Physical Address: 1019 Government St. Suite E

Mailing Address: 1019 Government St. Suite E

City: Ocean Springs State: MS Zip Code: 39564

Telephone: 888.574.7366 Fax: 228.875.5596

Toll Free Number: 888.574.7366

E-mail: info@primarypharmaceuticals.com Website: www.primarypharmaceuticals.com

Facility Manager: Frank Stumbo

Professional qualifications and experience of facility manager: Employed since 2013
see resume

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
 Hypodermic Devices
 Poisons or Chemicals
 Veterinary Legend Drugs
 Controlled Substances (include copy of DEA)
 Other: _____

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 Ownership Change
(Please provide current license number if making changes: WH _____)

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

Facility Name: Quinn Pharmaceuticals LLC

Physical Address: 7451 Wilcox Rd #201

Mailing Address: 7451 Wilcox Rd #201

City: Coral Springs State: FL Zip Code: 33067

Telephone: 954 755 0502 Fax: 954 755 0520

Toll Free Number: 844 477 8466

E-mail: namye@quinnrx.com Website: www.quinnrx.com

Facility Manager: Nanayam Fudler

Professional qualifications and experience of facility manager: Operations Manager

Types of licensed outlets or authorized persons firm will serve:

Pharmacies Practitioners Hospitals Wholesalers
 Other: major retailers & distributors

Type of Products to be handled or wholesaled by firm:

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

91964

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 Ownership Change
(Please provide current license number if making changes: WH _____)

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

Facility Name: R-Pharm US, LLC

Physical Address: 3120 Princeton Pike Suite 301 Lawrence, New Jersey 08648

Mailing Address: 3120 Princeton Pike Suite 301

City: Lawrence State: New Jersey Zip Code: 08648

Telephone: (609) 512 7211 Fax: (609) 228-5243

Toll Free Number: (908) 342 4585

E-mail: demetrios.kydonieus@rpharm-us.com Website: www.rpharm-us.com

Facility Manager: Jignesh Shah

Professional qualifications and experience of facility manager: 15 years of working experience in Pharmaceutical and Management Consulting related to 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 be firm:

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

92248

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.

<input checked="" type="checkbox"/> New Wholesaler (Virtual Manufacturer)	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH_____)
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Takeda Pharmaceuticals America, Inc.

Physical Address: One Takeda Parkway, Deerfield, IL 60015

Mailing Address: One Takeda Parkway

City: Deerfield State: IL Zip Code: 60015

Telephone: 224-554-6500 Fax: 224-554-7904

Toll Free Number: N/A

E-mail: karen.johnson@takeda.com Website: www.takeda.us

Facility Manager: Karen Johnson

Professional qualifications and experience of facility manager: More than 3 years as Distribution Manager; more than 8 years as Inventory Planning 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 Hypodermic Devices
 Poisons or Chemicals Veterinary Legend Drugs
 Controlled Substances (include copy of DEA)
 Other: _____

92232

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.

<input checked="" type="checkbox"/> New Wholesaler <input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH_____)

<input type="checkbox"/> Publicly Traded Corporation <input type="checkbox"/> Pages 1,2,3,4 <input type="checkbox"/> Partnership - Pages 1,2,3,6 <input checked="" type="checkbox"/> Non Publicly Traded Corporation <input type="checkbox"/> Pages 1,2,3,5a,5b <input type="checkbox"/> Sole Owner <input type="checkbox"/> Pages 1,2,3,7 Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: ZS Pharma, Inc.

Physical Address: 508 Wrangler Drive, Suite 100

Mailing Address: 508 Wrangler Drive, Suite 100, Coppell, TX 75019

City: Coppell State: TX Zip Code: 75019

Telephone: 650-753-1852 Fax: 972-393-1586

Toll Free Number: N/A

E-mail: licenses@zspharma.com Website: www.zspharma.com

Facility Manager: Maribel Peterson

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 Hypodermic Devices
 Poisons or Chemicals Veterinary Legend Drugs
 Controlled Substances (include copy of DEA)
 Other: _____

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92102

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.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change	(Please provide current license number if making changes: MP or MW _____)
<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6	
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> 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: Aero-Med, Ltd.

Physical Address: 5110 W. 74th Street, Indianapolis, IN 46268
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 7000 Cardinal Place, OCLC - QRA, Attn: Cynthia Rhodes

City: Dublin State: OH Zip Code: 43017

Telephone: 860-659-0602 Ext 280 Fax: 614-652-0282

E-mail: Gmb-Facility-Licensing@cardinalhealth.com Website: www.cardinal.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 7:00AM to 11:30PM Tue: 7:00Am to 11:30Pm Wed: 7:00Am to 11:30Pm Thu: 7:00Am to 11:30Pm
Fri: 7:00Am to 11:30Pm Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Richard Montovani, Director Operations Management

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

- | | |
|------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosethics |
| <input type="checkbox"/> Diabetic Supplies | Other: <u>Disposable Medical Supplies</u> |

**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: _____

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.

Ownership Change application form with checkboxes for New MDEG, Publicly Traded Corporation, Non Publicly Traded Corporation, Partnership, and Sole Owner. Includes license number MP00830.

FACILITY INFORMATION

Facility Name: Compression Solutions, LLC f/n/a Compression Solutions, Inc.

Physical Address: 817 E 4th Street, Tulsa, OK 74120

Mailing Address: 817 E 4th Street

City: Tulsa State: OK Zip Code: 74120

Telephone: 877-744-1078 Fax: 918-556-0156

E-mail: don.riker@compressionolutions.us Website: www.compressionolutions.us

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: on call to Sun: on call to Holidays: on call to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Don Riker, MANAGING EMPLOYEE

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 Prosthetics, Other: Sequential 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: N/A Telephone:

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: Precision Medical Products, Inc.

Physical Address: 2217 Plaza Dr. Rocklin, CA 95765
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 2217 Plaza Dr. Rocklin, CA 95765

City: Rocklin State: CA Zip Code: 95765

Telephone: 916-771-1525 Fax: 916-517-7464

E-mail: Stephanie@pmpmed.com Website: pmpmed.com

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: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: _____

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 Prosethetics
- 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: Jeremy Perkins Telephone: 916-509-2091

91965

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.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> 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: Pulse Flow Technologies Inc.

Physical Address: 34916 Ridge Road
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 34916 Ridge Road

City: Willoughby State: OH Zip Code: 44094

Telephone: (855)228-6200 Fax: (440)946-6201

E-mail: george.cagna@pulse-flow.net Website: www.pulse-flow.net

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 to 4 Tue: 8 to 4 Wed: 8 to 4 Thu: 8 to 4

Fri: 8 to 4 Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: George Cagna

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

- | | |
|-------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosethics |
| <input checked="" type="checkbox"/> Diabetic Supplies | Other: <u>Pulse Flow DF product; lymphedema pump</u> |

**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: _____

91851

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 MP00065)

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: Acadian Rehab, Inc
Physical Address: 175 S. Park St., Reno, NV 89502
(This must be a business address, we can not issue a license to a home address)
Mailing Address: 175 S. Park St.
City: Reno State: NV Zip Code: 89502
Telephone: 775-333-6600 Fax: 775-333-6601
E-mail: info@acadianrehab.com Website: acadianrehab.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 5:30 Tue: 9 to 5:30 Wed: 9 to 5:30 Thu: 9 to 5:30
Fri: 9 to 5:30 Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Aaron Stevens

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: _____

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.

<input type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change	<input checked="" type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH <u>00900</u>)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7,8a,8b	<input type="checkbox"/> Partnership - Pages 1,2,5,7,8a,8b
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Food Maxx Pharmacy #448

Physical Address: 565 East Prater Way

Mailing Address: _____

City: Sparks State: NV Zip Code: 89431

Telephone: (775)359-9069 Fax: (775)359-5866

Toll Free Number: (866)420-8412

E-mail: _____ Website: _____

Managing Pharmacist: Richard Cao License Number: 18845

Hours of Operation:

Monday thru Friday 9 am 7 pm Saturday 9 am 5 pm
Sunday ∅ am ∅ pm 24 Hours NA

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail	<input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> Parenteral
<input type="checkbox"/> Internet	<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Nuclear	<input type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> Out of State	<input type="checkbox"/> Mail Service
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Long Term Care

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.

<input checked="" type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH _____)			

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7,8a,8b	<input type="checkbox"/> Partnership - Pages 1,2,5,7,8a,8b
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Humana Pharmacy, Inc.

Physical Address: 1000 S. Rainbow Blvd, Las Vegas, NV 89145

Mailing Address: 1000 S. Rainbow Blvd

City: Las Vegas State: NV Zip Code: 89145

Telephone: 480-221-4951 Fax: 210-582-3620

Toll Free Number: Not available at this time. We will provide at a later date.

E-mail: jalthoff@humana.com Website: www.humanapharmacy.com

Managing Pharmacist: Jeffrey Althoff License Number: 19229

Hours of Operation:

Monday thru Friday	<u>8:30</u> am	<u>5:00</u> pm	Saturday	<u>N/A</u> am	<u>N/A</u> pm
Sunday	<u>N/A</u> am	<u>N/A</u> pm	24 Hours	<u>N/A</u>	

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail	<input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> Parenteral
<input type="checkbox"/> Internet	<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Nuclear	<input checked="" type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> Out of State	<input type="checkbox"/> Mail Service
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Long Term Care

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.

<input checked="" type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH _____)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7,8a,8b	<input type="checkbox"/> Partnership - Pages 1,2,5,7,8a,8b
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: MDRX, LLC

Physical Address: 1050 Wigwam Pkwy Ste #150

Mailing Address: 1050 wigwam Pkwy Ste #150

City: Henderson State: NV Zip Code: 89074

Telephone: 931-349-8300 Fax: 931-520-1345

Toll Free Number: _____

E-mail: mark@mdrxdispense.com Website: mdrxdispense.com

Managing Pharmacist: mark Casal License Number: 19217

Hours of Operation:

Monday thru Friday 9 am 6 pm Saturday 9 am 3 pm

Sunday 9 am 3 pm 24 Hours n/a

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail	<input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> Parenteral
<input type="checkbox"/> Internet	<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Nuclear	<input type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> Out of State	<input type="checkbox"/> Mail Service
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Long Term Care