

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 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: Care first Concierge Pharmacy
 Physical Address: 2235 E. Flamingo Rd #109 Unit E.
 Mailing Address: SAME AS ABOVE
 City: LAS Vegas State: NV Zip Code: 89121
 Telephone: 702 496-5880 Fax: _____
 Toll Free Number: _____
 E-mail: LRobinson@ContactAAC.com Website: _____
 Managing Pharmacist: LINDA DARLENE WILD License Number: 15374

Hours of Operation:

Monday thru Friday 9 am 5 pm Saturday _____ am _____ pm
 Sunday _____ am _____ pm 24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

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

This page must be submitted for all types of ownership.

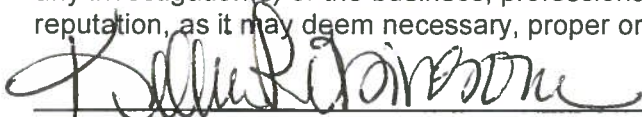
Within the last five (5) years:

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

If the answer to questions 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

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

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



Original Signature of Person Authorized to Submit Application, no copies or stamps

Kellie Robinson

Print Name of Authorized Person

March 16, 2016

Date

Board Use Only

Received:

3/28/16

Amount:

\$500.00

March 16,2016

Dear members of the Nevada State board of pharmacy,

I have enclosed with this letter an application for the licensure of a new pharmacy.

We will be a closed door pharmacy servicing patients participating in outpatient treatment programs here in the Las Vegas valley.

We will operate as a retail pharmacy, offering delivery of prescriptions to our patients who have recently transitioned to sober living facilities from residential treatment.

I have also enclosed a hand written diagram of the tentative design for the pharmacy layout.

We are excited to be part of the diverse community of pharmacies in the Las Vegas Valley and appreciate your consideration for licensure.



Kellie Robinson

Owner/Pharmacy Technician

Care First Concierge Pharmacy

Krobinson@contactaac.com

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Nevada
Parent Company if any: _____
Corporation Name: K. Robinson Holdings Corp.
Mailing Address: 2235 E. Flamingo Rd #109 Unit E
City: LAS Vegas State: NV Zip: 89121
Telephone: 702-496-5880 Fax: _____
Contact Person: Kellie Robinson

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

- a) Kellie Robinson 1190 Paradise desert Ave Henderson NV
Name Address
- b) _____
Name Address
- c) _____
Name Address
- d) _____
Name Address

NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

- 2) Provide the number of shares issued by the corporation. 1
- 3) What was the price paid per share? \$ 1.00
- 4) What date did the corporation actually receive the cash assets? 1/27/14
- 5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: _____ %: _____
Name: _____ %: _____

STATEMENT OF RESPONSIBILITY - Pharmacy
For Corporations, Partnership or Sole Owners

I, Kellie Robinson

Responsible Person of K. Robinson Holdings Corp.

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said company.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy or operation of a pharmacy in Nevada.

I further acknowledge and understand that upon the change of managing pharmacist in the pharmacy, the owners must assure that an accountability audit of all controlled substances shall be performed jointly by the departing managing pharmacist and the new managing pharmacist.

Kellie Robinson

Original Signature, no stamps or copies

March 11, 2016

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: LINDA DARLENE WILD

License #: 15374

Pharmacy Name: Care First Concierge Pharmacy

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

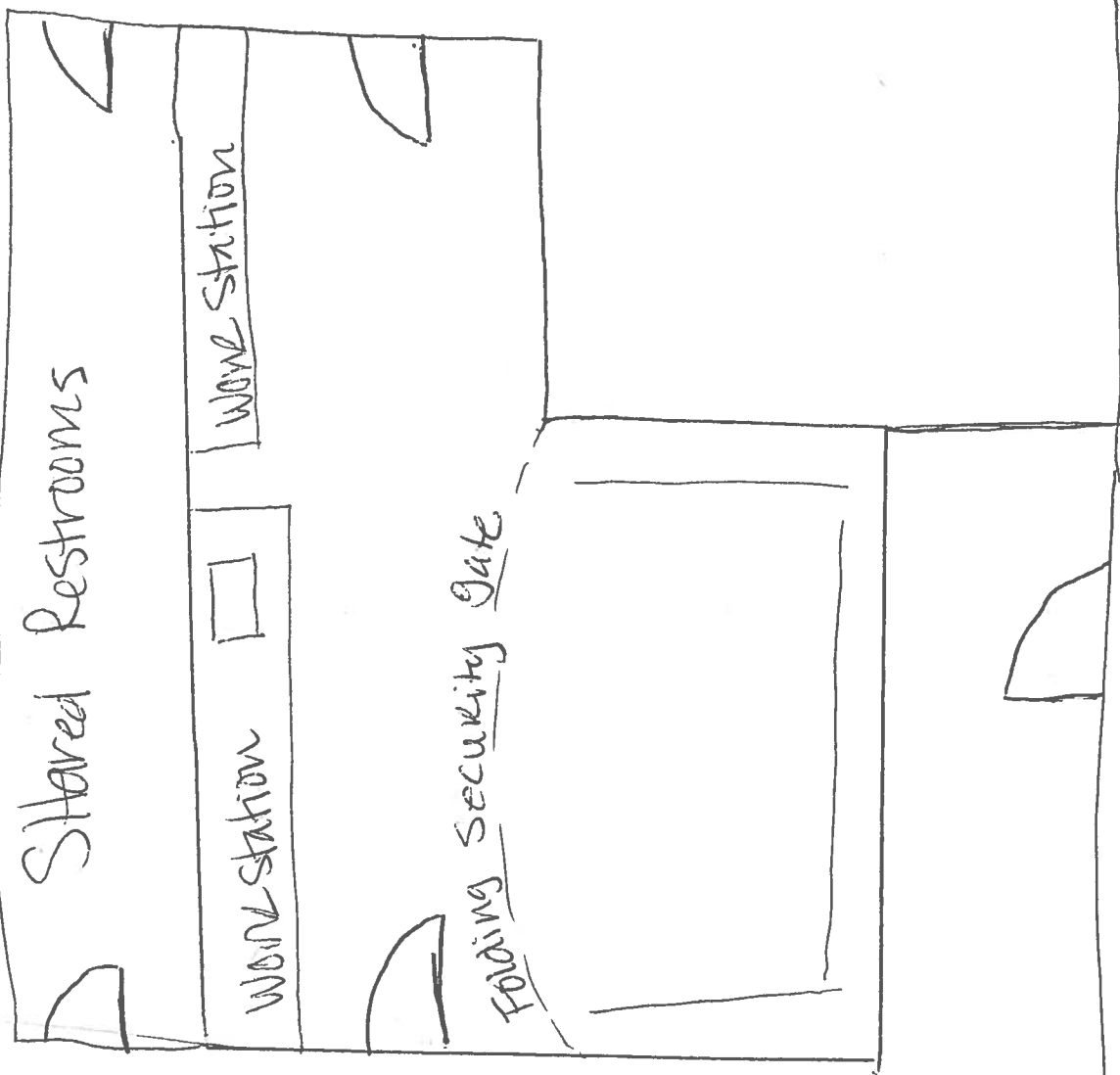
I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. been the subject of an administrative action whether completed or pending in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If you marked YES to any of the numbered questions above, please include the following information		
Board Administrative Action:	State: _____	Date: _____ Case #: _____
And/or Criminal Action:	State: _____	Date: _____ Case #: _____
	County: _____	Court: _____

Office Spaces

Care First Concierge Pharmacy
2235 E. Flamingo Rd, Las Vegas NV 89119

Common Hallway



Front Entrance

Front Entrance

Common Hallway

Office Spaces

April 7, 2016

Members of the Nevada State Board of Pharmacy:

My name is Darlene Wild. I will be working with Kellie Robinson in her new pharmacy – Care First Concierge Pharmacy.

I have been a licensed pharmacist in the state of Nevada since August of 2001. During my years of practice, I have gained experience as a retail pharmacist for both chain and independent pharmacies, worked in a mail order setting as a customer care pharmacist, managed the operations of a compounding pharmacy for an out of state owner and practiced within a rehab/detox hospital setting.

I am looking to utilize all of my experience – both as a pharmacist and as business manager – to work with Kellie to make her business a successful and lawfully compliant pharmacy.

I have known Kellie for many years as a technician and recently began to work with her again within the setting of Desert Hope Treatment Hospital. She and Shibu John RPH initiated the pharmacy service within this hospital and have made it a successful and integral part of the treatment program offered by its parent company – American Addiction Centers.

When the opportunity to provide pharmacy services to patients being treated as discharged outpatients was presented to Kellie, she asked if I would be willing to come onboard and I accepted at once. She has worked very hard on her business plan and on physically putting this pharmacy together and I am proud to help her with licenses, contracts, logistics and, of course, overseeing and verifying all prescriptions generated by her pharmacy.

Sincerely,

A handwritten signature in cursive script that reads "Darlene Wild". The signature is written in black ink and is positioned above the printed name.

L. Darlene Wild BSP, RPH

License 15374