

**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"/> <b>New Pharmacy</b> or <input type="checkbox"/> <b>Ownership Change</b> (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 checked="" type="checkbox"/> Sole Owner – Pages 1,2,6,7

**GENERAL INFORMATION to be completed by all types of ownership**

Pharmacy Name: ASPCares

Physical Address: 1401 E RIDGE RD UNIT B MCALLEN, TX 78503

Mailing Address: 13988 Diplomat Drive, Suite 100

City: Farmers Branch State: Texas Zip Code: 75234

Telephone: 956-284-6687 Fax: 956 284-6689

Toll Free Number: 844-800-9617 (Required per NAC 639.708)

E-mail: licensing@americanspecialtypharmacy.com Website: www.americanspecialtypharmacy.com

Managing Pharmacist: Ajeesha Abraham License Number: 49821

<b>TYPE OF PHARMACY</b>	<b>AND</b>	<b>SERVICES PROVIDED</b>
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 checked="" type="checkbox"/> <input 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 checked="" type="checkbox"/> <input type="checkbox"/> Outpatient/ <del>Discharge</del>
<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 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,**

93122

# APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.


Within the last five (5) years:

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

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

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

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

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

Bharat Pareek  
Print Name of Authorized Person

6/3/2016  
Date

Page 2

Board Use Only

Date Processed: 6/16/16

Amount: \$500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION**

State of Incorporation: Texas

Parent Company if any: N/A

Mailing Address: 13988 Diplomat Drive, Suite 100

City: Farmers Branch State: Texas Zip: 75234

Telephone: 214-919-2520 ext 309 Fax: 214-919-2524

Contact Person: Monica Penn

For any corporation non publicly traded, disclose the following:

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

a) Bharat Pareek 9189 Water Mill Rd Coppell, TX 75019-5149  
Name Address

b) \_\_\_\_\_  
Name Address

c) \_\_\_\_\_  
Name Address

d) \_\_\_\_\_  
Name Address

2) Provide the number of shares issued by the corporation. 1,000.000

3) What was the price paid per share? \$ .001

4) What date did the corporation actually receive the cash assets? N/A

5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: None %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

**Hours of Operation for the pharmacy:**

Monday thru Friday 9 am 5 pm Saturday Closed am \_\_\_\_\_ pm

Sunday Closed am \_\_\_\_\_ pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: Bharat Pareek

Business Name: ASPCares

Current Business Address: 13988 Diplomat Drive, Suite 100

City: Farmers Branch State: Texas Zip Code: 75234

Telephone: 214-919-2520 Fax: 469-661-9518

List any physician shareholders and percentage of ownership.

Name: Bharat Pareek %: 100

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

**Hours of Operation for the pharmacy:**

Monday thru Friday	<u>9</u> am	<u>5</u> pm	Saturday	<u>Closed</u> am	_____ pm
Sunday	<u>Closed</u> am	_____ pm	24 Hours	<u>N/A</u>	

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

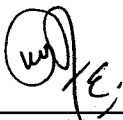
I, Bharat Pareek

Responsible Person of ASPCares

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

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

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



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

Bharat Pareek  
Print Name of Authorized Person

6/3/2016  
Date



## TEXAS STATE BOARD OF PHARMACY

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**Re:** ASPCARES

**Address:** 1401 East Ridge Road, Unit B  
McAllen, Texas 78503

**License No.:** 28586

**Date Issued:** June 6, 2013

**Licensure Status:** Active

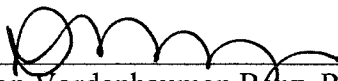
**Expiration Date:** June 30, 2017

**Type of Pharmacy:** Community – Class A

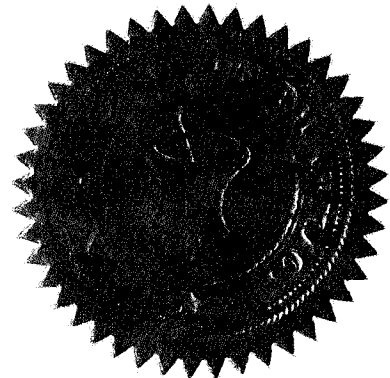
**Prior Disciplinary Orders:** No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. ASPCARES (Texas Pharmacy License #28586) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

  
\_\_\_\_\_  
Allison Vordenbaumen Benz, R.Ph., M.S.  
Director of Professional Services  
Texas State Board of Pharmacy

April 26, 2016  
Date



The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49<sup>th</sup> Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

**NEVADA STATE BOARD OF PHARMACY**

431 W Plumb Lane – Reno, NV 89509

**APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE**

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

**Publicly Traded Corporation** – Pages 1,2,3,7

**Partnership** - Pages 1,2,5,7

**Non Publicly Traded Corporation** – Pages 1,2,4,7

**Sole Owner** – Pages 1,2,6,7

**GENERAL INFORMATION to be completed by all types of ownership**

Pharmacy Name: Nanobots Healthcare, LLC (dba Assurance Infusion)

Physical Address: 2626 S Loop West, Ste 555

Mailing Address: 2626 S Loop West, Ste 555

City: Houston State: TX Zip Code: 77054

Telephone: 713-533-8800 Fax: 713-533-8802

Toll Free Number: 1-844-533-8800 (Required per NAC 639.708)

E-mail: nrl@assurance.care Website: www.assurance.care

Managing Pharmacist: Edward Nguyen License Number: 41069

**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,**

93216

# APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

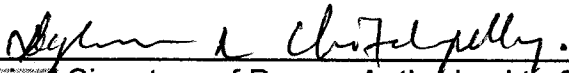
Within the last five (5) years:

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

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

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

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



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

Raghuveer Chintalapally

06/08/2016

Print Name of Authorized Person

Date

Page 2

Board Use Only

Date Processed: 6/28/16

Amount: \$500.00



APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION** LIMITED LIABILITY COMPANY

State of Incorporation: Texas

Parent Company if any: Nanobots Healthcare, LLC

Mailing Address: 2626 S Loop West, Ste 555

City: Houston State: TX Zip: 77054

Telephone: 713-533-8800 Fax: 713-533-8802

Contact Person: Raghuveer Chintalapally

For any corporation non publicly traded, disclose the following:

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

a) Raghuveer Chintalapally 2626 S Loop West, Ste 425,  
Name Address

b) Houston TX 77054  
Name Address

c) \_\_\_\_\_  
Name Address

d) \_\_\_\_\_  
Name Address

2) Provide the number of shares issued by the corporation. N/A

3) What was the price paid per share? N/A

4) What date did the corporation actually receive the cash assets? N/A

5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: N/A %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

**Hours of Operation for the pharmacy:**

Monday thru Friday 8 am 5:30 pm Saturday \_\_\_\_\_ am \_\_\_\_\_ pm  
Sunday \_\_\_\_\_ am \_\_\_\_\_ pm 24 Hours \_\_\_\_\_

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: \_\_\_\_\_

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

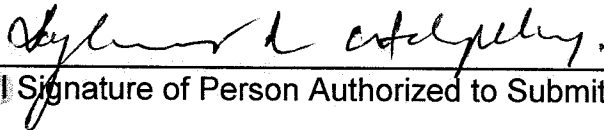
I, Raghuveer Chintalapally

Responsible Person of Nanobots Healthcare, LLC (dba Assurance Infusion)

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

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

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



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

Raghuveer Chintalapally

Print Name of Authorized Person

06/08/2016

Date



## TEXAS STATE BOARD OF PHARMACY

---

**Re:** Assurance Infusion

**Address:** 2626 South Loop West, Suite 555  
Houston, Texas 77054

**License No.:** 30391

**Date Issued:** December 16, 2015

**Licensure Status:** Active

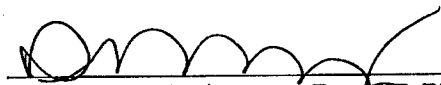
**Expiration Date:** December 31, 2017

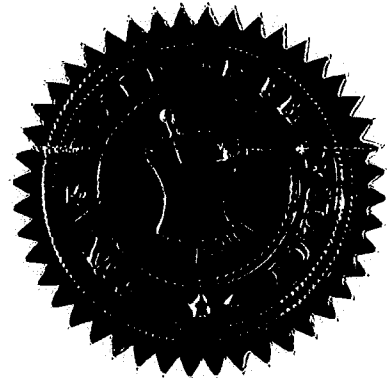
**Type of Pharmacy:** Community Sterile Compounding

**Prior Disciplinary Orders:** No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. Assurance Infusion (Texas Pharmacy License #30391) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

  
\_\_\_\_\_  
Allison Vordenbaumen Benz, R.Ph., M.S.  
Director of Professional Services  
Texas State Board of Pharmacy



March 29, 2016  
Date

The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49<sup>th</sup> Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

# NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

## APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Publicly Traded Corporation – Pages 1,2,3,7

Partnership - Pages 1,2,5,7

Non Publicly Traded Corporation – Pages 1,2,4,7

Sole Owner – Pages 1,2,6,7

### GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: SOUTH MIAMI PHARMACY II (C/O/B/A: SMP PHARMACY SOLUTIONS #2)

Physical Address: 7425 SW 42 ST MIAMI, FL 33155

Mailing Address: 7425 SW 42 ST

City: MIAMI State: FL Zip Code: 33155

Telephone: 305-740-9744 Fax: 866-301-1364

Toll Free Number: 855-255-5005 (Required per NAC 639.708)

E-mail: DANTES@SMPPHARMACY.COM Website: WWW.SMPPHARMACY.COM

Managing Pharmacist: JENNY LYNN ALFONSO License Number: PS40236 (FL)

#### 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,

91855

# APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

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

ARMANDO BARDISA, PHARM.D.  
Print Name of Authorized Person

02/02/2014  
Date

<b>Board Use Only</b>	Date Processed: <u>3/2/16</u>	Amount: <u>\$500.00</u>
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APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: ARMANDO BARDISA

Business Name: SOUTH MIAMI PHARMACY II (d/b/a: SMP PHARMACY SOLUTIONS #2)

Current Business Address: 7425 SW 42 ST

City: MIAMI State: FL Zip Code: 33155

Telephone: 305-740-9744 Fax: 866-301-1364

List any physician shareholders and percentage of ownership.

Name: N/A %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

**Hours of Operation for the pharmacy:**

Monday thru Friday 9:00 am 7:00 pm

Saturday 10:00 am 2:00 pm

Sunday — am — pm

24 Hours —

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

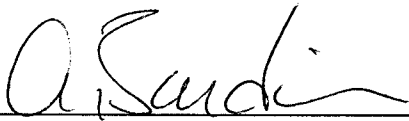
STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, ARMANDO BARDISA

Responsible Person of SOUTH MIAMI PHARMACY II (D/B/A: SMP PHARMACY SOLUTIONS #2)  
hereby acknowledge and understand that in addition to the corporation's, any owner(s),  
shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law  
that may occur in a pharmacy owned or operated by said corporation.

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

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



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

ARMANDO BARDISA, PHARM.

Print Name of Authorized Person

02/02/2016

Date

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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[ ] Publicly Traded Corporation – Pages 1,2,3,7

[ ] Partnership - Pages 1,2,5,7

[X] 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: Tailor Made Compounding

Physical Address: 200 Moore Dr Nicholasville, KY 40356

Mailing Address: same as above

City: Nicholasville State: KY Zip Code: 40356

Telephone: 859-887-0013 Fax: 859-406-1242

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

E-mail: jw@tailormadehealth.com Website: tailor-made-compounding.com

Managing Pharmacist: James Williams License Number: KY 015323

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- [X] [ ] Retail
[ ] [X] Hospital (# beds \_\_\_\_\_)
[ ] [X] Internet
[ ] [X] Nuclear
[ ] [X] Ambulatory Surgery Center
[ ] [X] Community
[ ] [X] Other: \_\_\_\_\_

All boxes must be checked
For the application to be complete

Yes/No

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

93207



**APPLICATION FOR OUT-OF STATE PHARMACY LICENSE**

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Within the last five (5) years:

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

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

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

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

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

James Williams  
Print Name of Authorized Person

13 June 2016  
Date

Page 2

Board Use Only

Date Processed: 6/28/16

Amount: \$500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

**OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION** LLC

State of Incorporation: Kentucky

Parent Company if any: N/A

Mailing Address: 200 Moore Dr

City: Nicholasville State: KY Zip: 40356

Telephone: 859-887-0013 Fax: 859-406-1242

Contact Person: James Williams

For any corporation non publicly traded, disclose the following:

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

a) Jeremy Delk 160 Hambroick Dr Nicholasville, KY 40356  
Name Address

b) \_\_\_\_\_  
Name Address

c) \_\_\_\_\_  
Name Address

d) \_\_\_\_\_  
Name Address

2) Provide the number of shares issued by the corporation. N/A

3) What was the price paid per share? N/A

4) What date did the corporation actually receive the cash assets? N/A

5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: Jeremy Delk %: 100

Name: \_\_\_\_\_ %: \_\_\_\_\_

**Hours of Operation for the pharmacy:**

Monday thru Friday 09 am 5 pm Saturday 10 am 4 pm  
Sunday Ø am Ø pm 24 Hours Ø

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, James Williams

Responsible Person of Taylor Made Compounding

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

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

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



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

James Williams

Print Name of Authorized Person

13 June 2016

Date

**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 02133)  
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: US Compounding

Physical Address: 1270 Dons Lane Conway, AR 72032

Mailing Address: P.O. Box 2709 Conway, AR 72033

City: Conway State: AR Zip Code: \_\_\_\_\_

Telephone: 501-327-1222 Fax: 501-499-8383

Toll Free Number: (800) 718-3588 (Required per NAC 639.708)

E-mail: licensing@uscompounding.com Website: www.uscompounding.com

Managing Pharmacist: Eddie Glover License Number: PD06232

**TYPE OF PHARMACY AND SERVICES PROVIDED**

- Yes/No
- Retail
- Hospital (# beds \_\_\_\_\_)
- Internet
- Nuclear
- Ambulatory Surgery Center
- Community
- Other: 503B

- 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: \_\_\_\_\_

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,

*no change from previous business model*