# NEVADA STATE BOARD OF PHARMACY

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

## APPLICATION FOR NEVADA PHARMACY LICENSE

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

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

Application must be printed legibly or typed

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

☑ New Pharmacy ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: PH_____)

☐ Publicly Traded Corporation ☐ Pages 1,2,3,7,8a,8b ☐ Partnership - Pages 1,2,5,7,8a,8b
☐ Non Publicly Traded Corporation ☐ Pages 1,2,4a,4b,7,8a,8b ☑ 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: All City Pharmacy, LLC.

Physical Address: 821 N. Lamb Blvd. #4, Las Vegas, NV 89110

Mailing Address: 821 N. Lamb Blvd. #4

City: LAS VEGAS State: NV Zip Code: 89110

Telephone: (725)465-7770 Fax: (725)465-7771

Toll Free Number: n/a

E-mail: hr@allcitypharmacy.com Website: www.AllCityPharmacy.com

Managing Pharmacist: Thanh v. Tran License Number: 13532

**Hours of Operation:**

Monday thru Friday 9:00 am 6:00 pm Saturday n/a am n/a pm

Sunday n/a am n/a pm 24 Hours n/a

| TYPE OF PHARMACY | SERVICES PROVIDED |
|---|---|
| ☑ Retail | ☐ Off-site Cognitive Services |
| ☐ Hospital (# beds ____) | ☐ Parenteral |
| ☐ Internet | ☐ Parenteral (outpatient) |
| ☐ Nuclear | ☐ Outpatient/Discharge |
| ☐ Out of State | ☐ Mail Service |
| ☐ Ambulatory Surgery Center | ☐ Long Term Care |



922357

## 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

Elen Zakaryan
Print Name of Authorized Person

03.17.2016
Date

**Board Use Only** Received: 3/28/16 Amount: $ 500.00

## APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: Elen Zakaryan

Business Name: All City Pharmacy, LLC.

Current Business Address: 821 N. Lamb Blvd.

City: Las Vegas State: NV Zip Code: 89110

Telephone: (725)465-7770 Fax: (725)465-7771

List any physician shareholders and percentage of ownership.

Name: Elen Zakaryan %: 100

Name: NA %: NA

Are you a registered pharmacist in Nevada? Yes ☐ No ☑ License #: _____

## SOLE OWNER

### Include with the application for a sole owner

Designated representative form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an examination on law **prior** to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

Complete personal history record. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*. Must be original signature(s), no copies or stamps.

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

I, Thanh v. Tran

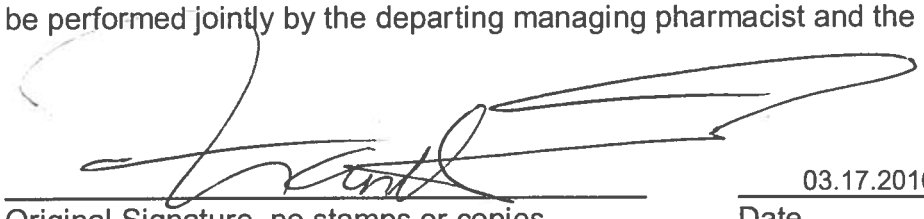
Responsible Person of All City Pharmacy, LLC.

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



Original Signature, no stamps or copies

03.17.2016
Date

## Statement of Responsibility

## Managing Pharmacist

Pharmacist Name: Thanh v. Tran License #: 13532

Pharmacy Name: All City Pharmacy, LLC.

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

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

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

| | Yes | No |
|---|---|---|
| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license? | ☐ | ☑ |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | ☒ | ☐ |
| 2. been the subject of an administrative action whether completed or pending in any state? | ☐ | ☑ |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | ☐ | ☑ |

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: NA Date: NA Case #: _____

And/or Criminal Action: State: MA Date: 12/18/01 Case #: 0156CR006765A

County SUFFOLK Court: QUINCY DISTRICT

Blank

# 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

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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 ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: PH_____)

☐ Publicly Traded Corporation – Pages 1,2,3,7,8a,8b ☐ Partnership - Pages 1,2,5,7,8a,8b
☒ Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b ☐ 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: JRobinson@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 |
|---|---|
| ☒ Retail | ☐ Off-site Cognitive Services |
| ☐ Hospital (# beds ____) | ☐ Parenteral |
| ☐ Internet | ☐ Parenteral (outpatient) |
| ☐ Nuclear | ☒ Outpatient/Discharge |
| ☐ Out of State | ☐ Mail Service |
| ☐ Ambulatory Surgery Center | ☐ Long Term Care |



92236

## 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 PUBLICY 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? 1/27/16

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

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

STATATEMENT 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 16, 2016
Date

## Statement of Responsibility

### Managing Pharmacist

Pharmacist Name: LINDA DARLENE WILD License #: 15374

Pharmacy Name: Cave 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? | ☐ | ☑ |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | ☐ | ☑ |
| 2. been the subject of an administrative action whether completed or pending in any state? | ☐ | ☑ |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | ☐ | ☑ |

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

# NEVADA STATE BOARD OF PHARMACY

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

## APPLICATION FOR NEVADA PHARMACY LICENSE

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☐ Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b ☒ 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: Community Outreach Medical Center Patient Pharmacy

Physical Address: 1140 Almond Tree Lane, Suite 306

Mailing Address: 1140 Almond Tree Lane, Suite 306

City: Las Vegas State: NV Zip Code: 89104

Telephone: (702) 657-3873 Fax: (702) 636-0787

Toll Free Number: N/A

E-mail: bcarlisle@nvcome.org Website: www.nvcomc.org

Managing Pharmacist: Hyeran Sung Yoon License Number: 14462

**Hours of Operation:**

~~Monday~~ thru ~~Friday~~ TUESDAY & WEDNESDAY 8 am 5 pm Saturday NA am NA pm

Sunday NA am NA pm 24 Hours NA

**TYPE OF PHARMACY**

- ☒ Retail – SEE ATTACHMENT, PAGE 1B
- ☐ Hospital (# beds ____)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☐ Ambulatory Surgery Center

**SERVICES PROVIDED**

- ☐ Off-site Cognitive Services
- ☐ Parenteral
- ☐ Parenteral (outpatient)
- ☒ Outpatient/Discharge SEE ATTACHMENT PAGE 1B
- ☐ Mail Service
- ☐ Long Term Care



92109

## 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

Ruben SAAVEDRA, MD
Print Name of Authorized Person

3-4-2016
Date

| Board Use Only | Received: 3/28/16 | Amount: $500.00 |
|---|---|---|

COMMUNITY OUTREACH MEDICAL CENTER
Bringing Community and Healthcare Together in Southern Nevada

MEMO

To: The Nevada State Board of Pharmacy

From: Community Outreach Medical Center

Subject: Per your request regarding the classification of our pharmacy:

Date: March 4, 2016

Community Outreach Medical Center is a 501(c)3, Primary Care Clinic caring for the medically uninsured and underinsured residents of Clark County. In addition to providing general medical care to patients, the clinic also offers Prenatal Care, Family Planning, STD testing and treatment, Immunizations, Cancer Screening for both men and women and comprehensive HIV/AIDS medical, nutritional and case management services through the Ryan White Care Act.

As a Ryan White provider we are able to participate in the Office of Pharmacy Affairs 340B pricing program. This program allows us to purchase patient medications at a substantially lower price than retail/wholesale and resell /bill insurances for market value or higher. The purpose of this program is provide health care programs such as ours to invest any money we recoup from the sale of these drugs back into our clinical programs. It is a mechanism that supports the existence and continuation of programs such as ours.

Participants in the 340 B pricing program, are required to adhere to certain requirements set forth by the Office of Pharmacy Affairs. One of these requirements is that we are only to offer these medications to our registered clinic patients. We cannot sell them to people coming in with prescriptions from other providers. As such, we are somewhat of a hybrid of a retail pharmacy.



1140 Almond Tree Lane, Suite 306• Las Vegas, NV 89104 • (702) 657-3873 • Fax: (702) 636-0787

www.nvcomc.org

## APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: Rubin Saavedra, M.D.

Business Name: Community Outreach Medical Center Patient Pharmacy

Current Business Address: 1140 Almond Tree Ln. Suite 306

City: Las Vegas State: NV Zip Code: 89104

Telephone: (702) 657-3873 Fax: (702) 636-0787

List any physician shareholders and percentage of ownership. (None)

Name: _____ %: _____

Name: _____ %: _____

Are you a registered pharmacist in Nevada? Yes ☐ No ☒ License #: _____

## SOLE OWNER

### Include with the application for a sole owner

Designated representative form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an examination on law **prior** to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

Complete personal history record. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*. Must be original signature(s), no copies or stamps.

## Statement of Responsibility

### Managing Pharmacist

Pharmacist Name: HYE RAN SUNG YOON License #: 14462

Pharmacy Name: Community Outreach Medical Center-Patient Pharmacy

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

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

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

| | Yes | No |
|---|---|---|
| Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license? | ☐ | ☒ |
| 1. been charged, arrested or convicted of a felony or misdemeanor in any state? | ☐ | ☒ |
| 2. been the subject of an administrative action whether completed or pending in any state? | ☐ | ☒ |
| 3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state? | ☐ | ☒ |

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

Blank