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: NEVADA STATE PHARMACY

Physical Address: 3022 W. POST ROAD, LAS VEGAS, NV 89118

Mailing Address: SAME

City: LAS VEGAS State: NV Zip Code: 89118

Telephone: 702-916-1600 Fax: 702-916-1900

Toll Free Number: —

E-mail: NVSPHARMACY@OUTLOOK.COM Website: NEVADASTATEPHARMACY.COM

Managing Pharmacist: MICHAEL BAILL License Number: 17004

Hours of Operation:

Monday thru Friday 8 am 6 pm Saturday 10 am 2 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

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.

Michael Brill

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

MICHAEL BRILL

Print Name of Authorized Person

8/29/2017

Date

Board Use Only Received: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

List names of 4 largest partners and percentage of ownership:

Name: JOHN M. MARTIN %: 34

Name: LOUIS GORDON LINDSEY %: 66

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: NEVADA STATE PHARMACY - LAS VEGAS, LLC

Mailing Address: 3022 POST ROAD

City: LAS VEGAS State: NV Zip Code: 89118

Telephone: 702-916-1600 Fax: 702-916-1900

Contact Person: JOHN M. MARTIN

List any physician shareholders and percentage of ownership.

Name: NONE %: _____

Name: _____ %: _____

PARTNERSHIP

Include with the application for a partnership

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 for each partner. 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: MICHAEL BRILL License #: 17004

Pharmacy Name: NEVADA STATE 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: _____

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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: QUIRE PHARMACY, LLC

Physical Address: 8205 Warm Springs Rd STE 100 LAS Vegas, NV 89113

Mailing Address: 1333 W. Belmont Ave Ste 320

City: Chicago State: IL Zip Code: 60657

Telephone: 800-266-4907 Fax: 877-992-3831

Toll Free Number: 800-266-4907

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

Managing Pharmacist: Patricia Majchrowski License Number: 19669

Hours of Operation:

Monday thru Friday 8 am 7 pm Saturday 10 am 4 pm

Sunday 8 am 7 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
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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.

Lindsay R. Cunningham

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

LINDSAY CUNNINGHAM

Print Name of Authorized Person

9/9/17

Date

Board Use Only	Received: _____	Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. **All persons listed as a partner must accurately complete a personal history record form.**

List names of 4 largest partners and percentage of ownership:

Name: Lindsay Cunningham %: 100

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: Quire Pharmacy, LLC

Mailing Address: 8205 Warm Springs Rd STE 100

City: Las Vegas State: NV Zip Code: 89113

Telephone: 847-757-5580 Fax: 877-992-3831

Contact Person: Matt Cunningham

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

PARTNERSHIP

Include with the application for a partnership

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 for each partner. 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: Patricia Majchrowski License #: 19669

Pharmacy Name: Quive 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.

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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?	☐	☒

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