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 02881)

☐ 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: LC VIP, LLC

Physical Address: 6875 RUSSELL RD. # 100, LAS VEGAS, NV 89118

Mailing Address: 130 CROSSWAYS PARK DR. STE 101

City: WOODBURY State: NY Zip Code: 11797

Telephone: 702-944-7446 Fax: 702-998-9492

Toll Free Number: n/a

E-mail: info@lindencare.com Website: n/a

Managing Pharmacist: Ralph Fiandra License Number: 08487

Hours of Operation:

Monday thru Friday 9 am 6 pm Saturday CLOSED ____am ____pm

Sunday CLOSED ____am ____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

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

Scott D. Kantor

Print Name of Authorized Person

3-15-2017

Date

Board Use Only	Received: 4·17·17	Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: LC Acquisition Corp, Inc.

Corporation Name: LC VIP, LLC

Mailing Address: 130 Crossways Park Dr. Ste. 101

City: Woodbury State: NY Zip: 11797

Telephone: 516 221 7600 Fax: 516 308 4339

Contact Person: Steve LaGreca

For any corporation non publicly traded, disclose the following:

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

a) Name: LC Acquisition Corp, Inc. Address: 130 Crossways Park Dr. Ste. 101, Woodbury, NY, 11797

b) Name: n/a Address: n/a

c) Name: n/a Address: n/a

d) Name: n/a Address: n/a

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. 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 n/a

List any physician shareholders and percentage of ownership.

Name: n/a %: n/a

Name: n/a %: n/a

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

I, Scott D. Kantor

Responsible Person of LC VIP, 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

3-15-2017

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Ralph Fiandra License #: 08487

Pharmacy Name: LC VIP, 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: _____ 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

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

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

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☐ Partnership - Pages 1,2,5,7,8a,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: West Valley Pharmacy

Physical Address: 6125 West Sahara Avenue, Suite 1A

Mailing Address: (same as above)

City: Las Vegas State: NV Zip Code: 89146

Telephone: 702 257 0508 Fax: N / A

Toll Free Number: N / A

E-mail: ____________ Website: N / A

Managing Pharmacist: Jayzle Joy Alviar Boyd License Number: 19506

Hours of Operation:

Monday thru Friday 8 am 8 pm Saturday 8 am 8 pm

Sunday 8 am 8 pm 24 Hours X

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

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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 ☒

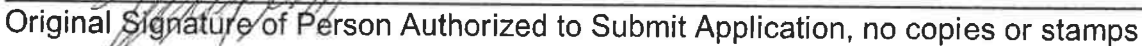
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Joseph Balous
Print Name of Authorized Person

03/21/2017
Date

Board Use Only	Received: 3/30/17	Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N / A

Corporation Name: West Valley Pharmacy LLC

Mailing Address: 6125 West Sahara Avenue, Suite 1A

City: Las Vegas State: NV Zip: 89146

Telephone: 702 257 0508 Fax: N / A

Contact Person: Joseph Balous

For any corporation non publicly traded, disclose the following:

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

a) Wynlous Spendthrift Trust, 1425 Astronomy Cir., Las Vegas, NV 89128
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. 100% Membership Interest

3) What was the price paid per share? $ 20.00 per unit (100 units = $ 2000.00 total)

4) What date did the corporation actually receive the cash assets? 3/29/2017 - estimated date the bank account will be opened and funded.

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: ______________________ %: ______

NEVADA STATE BOARD OF PHARMACY

431 W PLUMB LANE – RENO, NV 89509 - (775) 850-1440

This application cannot be returned by fax or email.
We must have an original signature and fee to process.

CHANGE OF MANAGING PHARMACIST FORM

Registration Fee: $50.00

(non-refundable money order or cashier's check only, no cash or business check's)

*This form is only required for pharmacies physically located in Nevada. We only require written notification from an out-of-state pharmacy for a manager change.

General Information **Nevada Pharmacy Board License #: ______

**(Do not use your RPH, NPI or DEA number. Number begins with a PH, IA, IB)

Pharmacy Name: West Valley Pharmacy Store #: ______

Address: 6125 W. Sahara Ave

City: Las Vegas State: * NV Zip: 89146

Telephone: ______ Fax: ______

New Managing Pharmacist Name: Alejandro Becerra

License #: 15184 Date Started: 4/15/17

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.

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.

	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 **(1-3)** above, include the following information & **provide documentation:**

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

Criminal Action:	State	Date:	Case #:	County	Court

Notification of Change in Employment

J Boyd [jayzlejoy@gmail.com]
Sent: Thursday, April 20, 2017 2:14 PM
To: Pharmacy Board

Good Afternoon,

I would like to notify the Board of Pharmacy that I, Jayzle Joy Boyd license #19506, will no longer be employed by:

Spring Valley Pharmacy
2725 S. Jones Blvd, Ste 101, Las Vegas, NV 89146

I would also like to request termination of consideration as Designated Representative for a Pharmacy application for the following:

West Valley Pharmacy
6125 W. Sahara Ave., Ste 1A, Las Vegas, NV 89146

Please do not approve any application with my name as the Pharmacy Manager. My final date of employment is April 28, 2017.

Thank you for your time and consideration regarding this matter.

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Best regards,

Jayzle Joy Boyd, Pharm.D.
License # 19506