

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: DE Craig Ranch, LLC dba Dignity St. Rose - Craig Ranch

Physical Address: 1550 West Craig Road, North Las Vegas, NV 89031

Mailing Address: 8686 New Trails Dr.

City: The Woodlands State: TX Zip Code: 77381

Telephone: 713-637-1009 Fax: 713-637-1305

Toll Free Number: _____

E-mail: tamarah.walker@emerus.com Website: www.strosenh.org

Managing Pharmacist: Heather Grolet, PharmD License Number: 19003

Hours of Operation:

Monday thru Friday _____ am _____ pm Saturday _____ am _____ pm
Sunday _____ am _____ pm 24 Hours x

TYPE OF PHARMACY

SERVICES PROVIDED

- | | |
|---|--|
| <input type="checkbox"/> Retail | <input type="checkbox"/> Off-site Cognitive Services |
| <input checked="" type="checkbox"/> Hospital (# beds <u>8</u>) | <input type="checkbox"/> Parenteral |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Parenteral (outpatient) |
| <input type="checkbox"/> Nuclear | <input type="checkbox"/> Outpatient/Discharge |
| <input type="checkbox"/> Out of State | <input type="checkbox"/> Mail Service |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> 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

Tamarah Walker, PharmD
Print Name of Authorized Person

2/2/17
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: DE JV, LLC %: 100
Name: _____ %: _____
Name: _____ %: _____
Name: _____ %: _____

Partnership Name: DE Craig Ranch, LLC

Mailing Address: 8686 New Trails Dr.

City: The Woodlands State: TX Zip Code: 77381

Telephone: 713-637-1009 Fax: 713-637-1305

Contact Person: David Stillwell

List any physician shareholders and percentage of ownership.

Name: N/A %: _____
Name: N/A %: _____

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 - Pharmacy
For Corporations, Partnership or Sole Owners

I, Tamarah Walker, PharmD

Responsible Person of DE Craig Ranch, LLC dba Dignity St. Rose - Craig Ranch

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

2/2/17

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Heather Crolet

License #: 19003

Pharmacy Name: Dignity St. Rose - Craig Ranch

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: _____

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<input type="checkbox"/> New Pharmacy	<input checked="" type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH_02898)			

<input 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: Nevada Health Rx

Physical Address: 61 Spectrum Blvd.

Mailing Address: 61 Spectrum Blvd.

City: Las Vegas State: NV Zip Code: 89101

Telephone: 702-637-0817 Fax: 702-637-1358

Toll Free Number: 866-737-3343

E-mail: Pending Website: Pending

Managing Pharmacist: Pamela Kalyan License Number: NV 15083

Hours of Operation:

Monday thru Friday 8:00 am 5:00 pm Saturday Closed am _____pm

Sunday Closed am _____pm 24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

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

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- 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

Greg Sundem

Print Name of Authorized Person

Date

2-1-17

Board Use Only

Received: _____ Amount: \$500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Nevada
Parent Company if any: Praxyn Corporation
Corporation Name: Nevada Health Rx, Inc.
Mailing Address: 61 Spectrum Blvd.
City: Las Vegas State: NV Zip: 89101
Telephone: 949-777-6112 Fax: _____
Contact Person: Kimberly Brooks

For any corporation non publicly traded, disclose the following:

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

- | | | |
|----|---------------------------|---|
| a) | <u>Praxyn Corporation</u> | <u>18013 Sky Park Circle, Suite A, Irvine, CA 92614</u> |
| | 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. 1,000,000
- 3) What was the price paid per share? \$0.12
- 4) What date did the corporation actually receive the cash assets? 1/2/17
- 5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: None %: 0

Name: _____ %: _____

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

I, Greg Sundem


Responsible Person of Nevada Health Rx

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

2-1-2017

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Pamela Kalyan License #: 15083

Pharmacy Name: Nevada Health Rx

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 checked="" type="checkbox"/>	<input 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: <u>NV</u>	Date: <u>12/2/2016</u> Case #: <u>16-087-RPH-S</u>
And/or Criminal Action:	State: _____	Date: _____ Case #: _____
	County: _____	Court: _____