NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

$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 MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Cpap store USA

Physical Address: 3325 W. Desert Inn RD Suite 201

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 3325 W. Desert Inn RD Suite 201

City: Las Vegas State: NV Zip Code: 89102

Telephone: 702-908-4852 Fax: 800-439-3194

E-mail: CpapStoreUSA@gmail.com Website: www.cpapstoreusa.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 10 to 5 Tue: 10 to 5 Wed: 10 to 5 Thu: 10 to 5

Fri: 10 to 5 Sat: 10 to 5 Sun: By appointment to 3 Holidays: N/A to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Oganes Berberyan

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

☐ Medical Gases**
☒ Respiratory Equipment**
☐ Life-sustaining equipment**
☐ Diabetic Supplies
☐ Assistive Equipment
☐ Parenteral and Enteral Equipment**
☐ Orthotics and Prosethics
Other: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Oganes Berberyan Telephone: 702-908-4852

95223

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☐ No ☒

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☒

3) Are any of the owners health professionals? If yes, please check the box and list name.

☐ Practitioner	Name: No
☐ Advanced Practitioner of Nursing	Name: No.
☐ Physician's Assistant	Name: No
☐ Physical Therapist	Name: No.
☐ Occupational Therapist	Name: No.
☐ Registered Nurse	Name: No.
☐ Respiratory Therapist	Name: No

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, 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 MDEG provider or wholesaler 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

Oganes Berberyan
Print Name of Authorized Person

11/1/16
Date

Board Use Only Received: _____ Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: Cpap Store USA LLC

Corporation Name: Cpap Store USA LLC

Mailing Address: 3325 W. Desert Inn RD Suite 201

City: Las Vegas State: NV Zip: 89102

Telephone: 702-908-4852 Fax: 800-439-3194

Contact Person: Oganes Berberyan

For any corporation non publicly traded, disclose the following:

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

a) Oganes Berberyan (Name) 3325 W. Desert Inn RD Suite 201 (Address)

b) N/A (Name) (Address)

c) N/A (Name) (Address)

d) N/A (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. 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

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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 MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☑ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: EQUITABLE HOME MEDICAL SUPPLY INC.

Physical Address: 1404 S. DECATUR BLVD. LAS VEGAS NV 89102

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1404 S. DECATUR BLVD.

City: LAS VEGAS State: NV Zip Code: 89102

Telephone: 702-331-3882 Fax: 702-331-6878

E-mail: POLFLORES@YAHOO.COM Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 5 Tue: 9 to 5 Wed: 9 to 5 Thu: 9 to 5

Fri: 9 to 5 Sat: 9 to 3 Sun: ___ to ___ Holidays: ___ to ___

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: CORAZON ZAMORA

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

☐ Medical Gases**
☐ Respiratory Equipment**
☐ Life-sustaining equipment**
☐ Diabetic Supplies
☐ Assistive Equipment
☐ Parenteral and Enteral Equipment**
☑ Orthotics and Prosethics
Other: INCONTINENT SUPPLIES

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: CORAZON ZAMORA Telephone: 702-331-3882

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

N/A _____ _____ _____

_____ _____ _____

_____ _____ _____

1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☐ No ☑

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☑

3) Are any of the owners health professionals? If yes, please check the box and list name.

☐ Practitioner	Name: N/A
☐ Advanced Practitioner of Nursing	Name: _____
☐ Physician's Assistant	Name: _____
☐ Physical Therapist	Name: _____
☐ Occupational Therapist	Name: _____
☐ Registered Nurse	Name: _____
☐ Respiratory Therapist	Name: _____

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, 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 MDEG provider or wholesaler 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

LEOPOLDO FLORES
Print Name of Authorized Person

12/12/2016
Date

Board Use Only	Received:	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: _____

Corporation Name: EQUITABLE HOME MEDICAL SUPPLY INC.

Mailing Address: 1404 S. DECATUR BLVD.

City: LAS VEGAS State: NV Zip: 89102

Telephone: 702-331-3882 Fax: 702-331-6878

Contact Person: LEOPOLDO FLORES

For any corporation non publicly traded, disclose the following:

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

a) LEOPOLDO FLORES 11894 PRINCIPI CT. LAS VEGAS NV 89183
Name Address

b) N/A
Name Address

c) N/A
Name Address

d) N/A
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. 1500

3) What was the price paid per share? $0.01

4) What date did the corporation actually receive the cash assets? 12/13/2016

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 12/12/2016

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for DURABLE MEDICAL EQUIPMENT
Nature of MDEG

EQUITABLE HOME MEDICAL SUPPLY INC. 1404 S. DECATUR BLVD LAS VEGAS NV 89102
Name and Address of Business for Which MDEG Administrator Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

ZAMORA — Last Name
CORAZON — First Name
PIEDAD — Middle Name

N/A
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

11894 PRINCIPI CT — Present Residence Address-Street or RFD
LAS VEGAS — City
NV 89138 — State/Zip

1404 S. DECATUR BLVD. — Present Business Address
Dates
LAS VEGAS — City
NV 89102 — State/Zip

ADMINISTRATOR — Present Position with the MDEG
Dates

Phone: 702-331-3552
Fax: 702-331-6578

Email address:

Date of Birth
TARLAC TARLAC PHILIPPINES — Place of Birth (City, County, State)

49 — Age
Social Security Number
FEMALE — Sex

BROWN — Color of Eyes
BLACK — Color of Hair
165 LBS. — Weight
5'6 — Height

Scars, tattoos or distinguishing marks and/or characteristics N/A

N/A

Are you a citizen of the United States? Yes ☐ No ☑

If alien, registration No

If naturalized, certificate No N/A Date N/A

Place N/A (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

	PREFERRED HOMECARE	
07/2013 - 12/2016	871 GRIER DR. STE.C LAS VEGAS NV 89119	1280 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
PATIENT SERVICE SPECIALIST	ANSWERING PHONE INQUIRIES, VERIFY ELIGIBILITY PROCESS ORDERS ETC.	IRENE RODRIGUEZ
Title	Description of Duties	Name of Supervisor
	METROSTAR HOME HEALTH PRODUCTS	
08/2011 - 01/2013	5359 KINGS HWY BROOKLYN NY 11203	5040 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
BILLING REPRESENTATIVE	PROCESS PRESCRIPTION, VERIFY ELIGIBILITY BILLING MEDICARE, MEDICAID AND OTHER INSURANCE	LIOUDA MALKINA
Title	Description of Duties	Name of Supervisor
	KINGS PHARMACY & SURGICAL	
02/2011 - 08/2011	492 CLARKSON AVE. BROOKLYN NY 11203	1040 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
PHARMACY CLERK	TYPING PRESCRIPTIONS AND BILLING INSURANCES	ROY GREIF
Title	Description of Duties	Name of Supervisor
	GENERAL HOME MEDICAL SUPPLY	
03/2006 - 02/2009	717 LAKEFIELD RD STE.D WESTLAKE VILLAGE CA 91361	6450 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
QUALIFIER / MEDICAL BILLER (N/A)	PROCESS PRESCRIPTION, VERIFY ELIGIBILITY AND BILL INSURANCES	KAMBIZ YADIDI
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor

I have ☐ I have not ☑ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☑ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☑ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☑ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action:
b)

State: N/A

Date: N/A

Case Number: N/A

c) Criminal Action:

State: N/A

Date: N/A

Case Number: N/A

County: N/A

Court: N/A

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☑ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☑ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☑ No ☐

If you answer No to questions 4, 5 or 6 please provide a writte

N/A

Date of photograph 12/13/16

I, CORAZON ZAMORA, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Czamora
Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/12/2010

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for DURABLE MEDICAL EQUIPMENT
Nature of License

EQUITABLE HOME MEDICAL SUPPLY INC. 1404 S. DECATUR BLVD. LAS VEGAS NV 89102
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
FLORES	LEOPOLDO	AGUILA

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

N/A

Present Residence Address-Street or RFD	Dates	City	State/Zip
11594 PRINCIPI CT		LAS VEGAS	NV 89183
Present Business Address	**Dates**	**City**	**State/Zip**
1404 S. DECATUR BLVD		LAS VEGAS	NV 89102

Occupation: DIRECTOR OF GRANT ACCOUNTING

Phone: Residence

Business 702-892-2330

Date of Birth	Place of Birth (City, County, State)	
	CALOOCAN CITY PHILIPPINES	(~~MALE~~)
Age	**Social Security Number**	**Sex**
50		MALE

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
BROWN	BLACK		170 LBS.	MEDIUM	5'4

Scars, tattoos or distinguishing marks and/or characteristics N/A

Are you a citizen of the United States? Yes ☐ No ☑ If alien, registration No

If naturalized, certificate No N/A Date N/A

Place N/A (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☑ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial