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 Las Vegas

Physical Address: 4533 W. Sahara Ave. Unit 4 Las Vegas, NV 89102

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

Mailing Address: 4533 W. Sahara Ave. Unit 4

City: Las Vegas State: NV Zip Code: 89102

Telephone: 702-485-1847 Fax: 702-920-8366

E-mail: CPAPStoreNV@gmail.com Website: www.cpapstorevegas.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9am to 5pm Sat: 9am to 5pm Sun: 10am to 3pm Holidays: 9am to 1pm

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Tony Maltesee

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: Tony Maltesee Telephone: 702-321-7544

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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: _____
☐ Advanced Practitioner of Nursing	Name: _____
☐ Physician's Assistant	Name: _____
☐ Physical Therapist	Name: _____
☐ Occupational Therapist	Name: _____
☐ Registered Nurse	Name: _____
☒ Respiratory Therapist	Name: Tony Maltese

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

Gevorg Muradyan
Print Name of Authorized Person

05-28-2017
Date

Board Use Only	Received: _____	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Gevorg Muradyan

Business Name: CPAP STORE Las Vegas

Current Business Address: 4533 W. Sahara Ave. Unit 4

City: Las Vegas State: NV Zip: 89102

Telephone: 702-485-1847 Fax: 702-920-8366

SOLE OWNER

Include with the application for a sole owner

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 05-25-2017

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 DME

Nature of MDEG

CPAP Store Las Vegas - 4533 W. Sahara Ave Unit 4. Las Vegas, NV 89102

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

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1. PERSONAL INFORMATION:

Maltese — Last Name
Tony — First Name
Middle Name

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

9354 Cowboy Rain Drive . Las Vegas, NV 89178
Present Residence Address-Street or RFD — City — State/Zip

4533 W. Sahara Ave #4 — Dates May 2017^ — Las Vegas — NV, 89102
Present Business Address — City — State/Zip

Respiratory Therapist — Dates May 207 - Present.
Present Position with the MDEG

Phone: 702-321-7544 — Fax:

Email address:

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

52 — Age
Social Security Number
Male — Sex

Green — Color of Eyes
BAL — Color of Hair
210 — Weight
5'10 — Height

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 — Date

Place (If naturalized, document must be verified.)

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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.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
mAy /2017	CPAP Store Las Vegas	PRESENT
Title	**Description of Duties**	**Name of Supervisor**
Respiratory Therapist	Answering Patient Questions.	Gevorg.
Jan - May /2015	St. Josephs Long Term Care Facility	800
Respiratory Therapist	Patient treatment Follow-ups - Diagnostic test and Reviews.	Cmari Cooper.
Jan - April 2016	Horizon Long Term Care Facility	640- Scott Reids
Respiratory Therapist	Patient Interview/treatment Follow-up - Educating patient on treatment and equipment.	
OCT-NOV / 2014	Spring Valley Hospital	320
Respiratory Therapist	Conducting Dignostic tests/monitoring patient progress and treatment / Patient education on equipment.	Brian
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

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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: State: _____
b)

Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

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 written le

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Date of photograph.....

I, TONY MACRESC, 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.

Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date .....

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 Georg Muradyan
Nature of License

CPAP Store Las Vegas - 4533 W. Sahara Ave. Unit 4 - Las Vegas, NV 89102
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION: Muradyan, Georg

Last Name | First Name | Middle Name

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

7082 Somera Way | Las Vegas | NV 89113
Present Residence Address-Street or RFD | City | State/Zip

4533 W. Sahara Ave. | Dates 2015-PRESENT | Las Vegas, NV 89102
Present Business Address | City | State/Zip

Owner | Dates 2015- PRESENT
Occupation | Phone: Residence

Yerevan, Armenia | Business 702-485-8647
Date of Birth | Place of Birth (City, County, State)

29 | Male
Age | Social Security Number | Sex

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Black	Black	Fair	180	Average	5'10

Scars, tattoos or distinguishing marks and/or characteristics NO

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

If naturalized, certificate No ..... Date .....

Place ..... (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial GM

MARITAL INFORMATION-Continued

A. **Current Marriage** n/a
Date City, County and State

Spouse's full name (Maiden) S.S. No

Date of Birth Place of Birth

Resident address
Street City State Zip

Telephone: Residence Business

Spouse's employer Occupation

Address of employer
Street City State Zip

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
	n/a			

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone
	n/a				

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
	n/a		

B. Child Support Information:

Please mark the appropriate response:

☒ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial CM