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: PAM Rehabilitation Hospital of Centennial Hills

Physical Address: 6166 N. Durango Drive, Las Vegas, NV 89149

Mailing Address: 1828 Good Hope Rd., Ste. 101

City: Enola State: PA Zip Code: 17025

Telephone: Facility is under construction - can provide telephone, fax and toll free number upon completion of construction Fax: _____

Toll Free Number: _____

E-mail: drencher@postacutelasvegas.com Website: www.postacutemedical.com

Managing Pharmacist: Eric Shalita License Number: 18634

Hours of Operation:

Monday thru Friday 8:00 am 4:30 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours _____

TYPE OF PHARMACY

- ☐ Retail
- ☒ Hospital (# beds 44)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☐ Ambulatory Surgery Center

SERVICES PROVIDED

- ☐ Off-site Cognitive Services
- ☒ Parenteral
- ☐ Parenteral (outpatient)
- ☐ Outpatient/Discharge
- ☐ Mail Service
- ☐ Long Term Care

97331

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 ☒

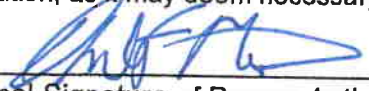
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Anthony F. Mistano

Print Name of Authorized Person

6/22/17

Date

Board Use Only Received: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Pennsylvania

Parent Company if any: PAM Squared, LLC

Corporation Name: PAM Squared at Las Vegas, LLC

Mailing Address: 1828 Good Hope Road, Suite 102

City: Enola State: PA Zip: 17025

Telephone: 717-731-9660 Fax: 717-695-0318

Contact Person: Ilene Oken, Assistant General Counsel

For any corporation non publicly traded, disclose the following:

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

a) PAM Squared, LLC (Name) 1828 Good Hope Rd., Ste. 102, Enola, PA 17025 (Address) sole owner is a limited liability company

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.* See attached explanation

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

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: N/A %: _____

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

I, Anthony F. Misitano

Responsible Person of PAM Squared at Las Vegas, LLC d/b/a PAM Rehabilitation Hospital of Centennial Hills 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

10/22/17
Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Eric Shalita License #: 18634

Pharmacy Name: PAM Rehabilitation Hospital of Centennial Hills

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? ☐ ☒ (No)		
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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Application must be printed legibly or typed

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☒ 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: Spring Valley Surgery Center

Physical Address: 8829 Mohawk St. Las Vegas, NV 89139

Mailing Address: _____

City: Las Vegas State: NV Zip Code: 89103

Telephone: (702)-927-4440 Fax: _____

Toll Free Number: N/A

E-mail: spence@npimedical.com Website: www.lasvegaspaininstitutes.com

Managing Pharmacist: Douglas Frederick Lammam License Number: 13340

Hours of Operation:

Monday thru Friday 0800 am 1600 pm Saturday 0800 am 0430 pm

Sunday Ø am Ø pm 24 Hours Ø

TYPE OF PHARMACY

- ☐ Retail
- ☐ Hospital (# beds ____)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☒ Ambulatory Surgery Center

SERVICES PROVIDED

- ☐ Off-site Cognitive Services
- ☐ Parenteral
- ☒ Parenteral (outpatient)
- ☒ Outpatient/Discharge
- ☐ Mail Service
- ☐ Long Term Care

96685

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

Godwin Maduka, MD
Print Name of Authorized Person

04/17/2017
Date

Board Use Only Received: _____ 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: Spring Valley Surgery Center, LLC

Mailing Address: _____

City: Las Vegas State: NV Zip: _____

Telephone: (702) 227-4440 Fax: _____

Contact Person: epence@vpimedical.com

For any corporation non publicly traded, disclose the following:

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

a) Shares were not issued to individuals.
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. Ø

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

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

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

I, Godwin Maduka

Responsible Person of Spring Valley Surgery Center, 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

Date 04/17/2017

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Douglas Cammann License #: 13340

Pharmacy Name: Spring Valley Surgery Center

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: NV / OR Date: 08/20/2015 / 04/26/1994 Case #: 15-049-RPH-S / 93-0181-B

And/or Criminal Action: State: OR Date: 05/04/1989 Case #: CR-890399-D

County: Benton Court: District

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(Please provide current license number if making changes: PH 02771)

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☐ 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: WELLCARE LTC PHARMACY

Physical Address: 4101 WAGON TRAIL. AVE LAS VEGAS NV 89118

Mailing Address: 4101 WAGON TRAIL AVE

City: LAS VEGAS State: NV Zip Code: 89118

Telephone: 702 576 9545 Fax: 702 946 0353

Toll Free Number: N/A

E-mail: SARIF.CHOR@YAHOO.COM Website: N/A

Managing Pharmacist: ASHKAN MOUSAVINASAB License Number: 15440

Hours of Operation:

Monday thru Friday 9 am 7 pm Saturday 11 am 5 pm

Sunday ϕ am ϕ pm 24 Hours ϕ

TYPE OF PHARMACY

- ☐ Retail
- ☐ Hospital (# beds ____)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☐ Ambulatory Surgery Center

SERVICES PROVIDED

- ☐ Off-site Cognitive Services
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