NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509

APPLICATION FOR OUT-OF-STATE 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 or Common Chang e (Provide current license number if making changes: PHO}??® Check box below for type of ownership and complete all required forms.								
Publicly Traded Corporation - Pages 1 2 3 7								
☐ Non Publicly Trace	☐ Non Publicly Traded Corporation – Pages 1,2,4,7 ☐ Sole Owner – Pages 1,2,6,7							
GENERAL INFOR	GENERAL INFORMATION to be completed by all types of ownership							
Pharmacy Name:			-	VS/specialty Infusion Services				
Physical Address:	4601 E. Hilton Ave., Ste. 10	05, Phoenix, AZ	Z 85034	1				
Mailing Address:	One CVS Drive, Licensing	Dept/MC 1160						
City: Woonsocket		State:	RI	Zip Code:				
Telephone: 480-2	240-3209	Fax:	505-045	555				
Toll Free Number:		(Red	quired	per NAC 639.708)				
E-mail: kimberly.mitchell@cvshealth.com Website				800-697-1667				
Managing Pharma	License Number:							
TYPI	E OF PHARMACY	AND	SEI	RVICES PROVIDED				
Yes/N	No		Yes	s/No				
	Retail			Off-site Cognitive Services				
	Hospital (# beds)	W	□ Parenteral **				
	Internet		W	☐ Parenteral (outpatient)				
	Nuclear			Outpatient/Discharge				
	☐ ☐ Ambulatory Surgery Center			☐ Mail Service				
☑ Community		Jenter		Mail Service				
	☐ Community	0		Mail Service Long Term Care				
		0						
	☐ Community	0		Long Term Care				
<u> </u>	☐ Community	0		□ Long Term Care □ Sterile Compounding **				
All bo	□ Community □ Other: <u>May</u> ~ <u>Res</u>	Dent		Long Term Care Sterile Compounding ** Non Sterile Compounding				

^{**}If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within	the last five	(5) years:						
1)	any interest	poration, any owner(s), c, ever been charged, or or (including by way of	convicted of a fel	ony or gros	ss	Yes □	No	□X
2)		poration, any owner(s), , ever been denied a lic ?	, ,	. , ,	with	Yes □	No	□x
3)	interest, eve	poration, any owner(s), er been the subject of a proceeding relating to th	n administrative a	ction, board		Yes □	No	↳
4)	interest, eve	poration, any owner(s), er been found guilty, ple to any offense federal o ?	d guilty or entered	a plea of r		Yes □	No	□ X i
5)	interest, eve	poration, any owner(s), er surrendered a license or otherwise (other than	e, permit or certific	ate of regis	tration	Yes □	No	⅓
Copies	answer to qu s of any doc sition may be	estion 1 through 5 is "younger that identify the required.	es", a signed state circumstance or c	ement of ex contain an o	planation morder, agree	nust be a ement, o	attach r othe	n <mark>ed</mark> er
correc	t. I understa	t the answers given in t and that any infraction o thorized pharmacy may	f the laws of the S	tate of Nev	ada regulat	ting the	true a	and
under correc emplo	penalty of po t. I hereby a yees, to con	stions, answers and sta erjury, that the informati outhorize the Nevada St duct any investigation(s ication and reputation, o	on furnished on th ate Board of Phar) of the business,	nis applicati macy, its ag professiona	on are true, gents, serva al, social an	, accura ants and nd moral	te an	rtify d
Origina	al Signature	of Person Authorized to	Submit Application	on, no copie	es or stamp	S		
	s S. Moffatt			1/3	113018			
Print N	lame of Auth	norized Person		Date		Pa	age 2	2
Board	Use Only	Daté Processed:		Amount:	\$500.0			

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of	Incorporation	n:						
Parent 0	Company if a	ny: Coram Specialty 1	nfusion Ser	vices, L.L.	C			
Mailing A	Address: O	One CVS Drive						
City:	Woonsocket		State:	RI	Zip: _	0289	5	
Telepho	one: 401-770-0	6431	Fa	ax:40	1-216-0381			
Contact	Person:	Kimberley DeSousa						
		non publicly traded, o	disclose	the follo	wing:			
						rporatio	nn?	
1) L	• •	sons to whom the shand specialty Infusion Service						
а	1)	Name		Idress	of memocran	iip interes		
L								
a)	Name	Ac	Idress				
С	:)							
		Name	Ac	Idress				
d	l)	Nama	Λ.	Idress				
		Name						
2) F	Provide the ni	umber of shares issu	ied by th	e corpor	ation			
3) V	What was the	price paid per share	?					-
4) V	What date did	d the corporation act	ually rece	eive the	cash asse	ts?		
		by of the corporation'						
Liet any	, nhveician et	nareholders and perc	entage (of owner	shin			
		Tarefloiders and perc					0/0.	
name:							70.	
<u>Hours</u>	of Operation	for the pharmacy:						
Monday	y thru Friday	8am <u>5</u>	pm		Saturd	day	noam	pn
5	Sunday	noam	pm		24 Ho	urs	No	
A Neva license	da business please provi	license is not required	ed, howe	ver if the	e pharmac	y has a	Nevada bu	isiness

STATEMENT OF RESPONSIBILITY FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I,Thomas S. Moffatt
Responsible Person of Coram Alternate Site Services, Inc. dba: Coram CVS/specialty infusion services
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 corporation.
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.
Original Signature of Person Authorized to Submit Application, no copies or stamps
Thomas s. Moffatt, Vice President/Secretary 1/31/26 \8
Print Name of Authorized Person Date

AFFIDAVIT for Out-of-State Pharmacy License

<i>1.</i>
STATE OF AVIZORQ) ss.
Maricopa county)
I, Richard Monty , hereby certify that the assertions in this Affidavit
are true and correct to the best of my knowledge and belief, and state as follows:
1. I am the Pharmacist-in-Charge for olda Covern CVS Specialty (the
Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.
2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile
products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-
of-State Pharmacy License.
3. I understand and acknowledge that the Pharmacy and any of its Nevada-
registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells
or ships any compounded sterile product into Nevada without first obtaining written authorization
from the Board to do so.
4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile
product into Nevada, the Pharmacy, through an authorized representative, will first notify the
Board and obtain written approval to sell and ship such products into Nevada.
5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile
product into Nevada, an authorized representative of the Pharmacy may be required to appear
before the Board to answer questions before such approval is granted.
FURTHER AFFIANT SAYETH NOT.
I, Pickeral Monday do hereby swear under penalty of perjury that the assertions of this
affidavit are true.
Name
SUBSCRIBED AND SWORN TO
before me, a notary public this 29 day of <u>Tanuara</u> , 2018.
KIRSTIN A THONER
NOTARY PUBLIC Notary Public - Arizona Maricopa County

Revised

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509

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-Now Dharmany ar	=Ourseashin Observe /D :						
	☐New Pharmacy or ☐Ownership Change (Provide current license number if making changes: PH Check box below for type of ownership and complete all required forms.						
☐ Publicly Traded Corporation – Pages 1,2,3,7 ☐ Partnership - Pages 1,2,5,7 ☐ Non Publicly Traded Corporation – Pages 1,2,4,7 ☐ Sole Owner – Pages 1,2,6,7							
☐ Non Publicly Tradeo	d Corporation - Pages 1,2,4,7		Sole Owner – Pages 1,2,6,7				
CENEDAL INCODA	ATION to be consisted to		of according				
	ATION to be completed by						
			ram CVS/specialty infusion service #48078				
	310 East Cotton Center Blvd, Su	uite 110, Ph	oenix, AZ 85040				
Mailing Address: Or	ne CVS Drive, MC #1160						
		RI	Zip Code: 02895				
	7888 Fax: 6						
Toll Free Number: _	800-530-1199	(Required	l per NAC 639.708)				
Managing Pharmacis	st: Amish Kapadia		License Number: S021813				
TYPE (OF PHARMACY AND	SE	RVICES PROVIDED				
Yes/No		-	s/No				
	Retail		☑ Off-site Cognitive Services				
	Hospital (# beds)	X	☐ Parenteral **				
	Internet	X	☐ Parenteral (outpatient)				
	Nuclear	X	☐ Outpatient/Discharge				
	Ambulatory Surgery Center		☑ Mail Service				
	Community		☑ Long Term Care				
	Other: Home Infusion	X	☐ Sterile Compounding **				
			☑ Non Sterile Compounding				
All boxes	s must be checked		☐ Mail Service Sterile Compounding **				
For the a	application to be complete		☑ Other Services:				

^{**}If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,

APPLICATION FOR OUT-OF STATE 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 any interest, ever been charged, or convicted of a fel misdemeanor (including by way of a guilty plea or no	ony or gross	Yes □ No 🛚			
2)	Has the corporation, any owner(s), shareholder(s) or any interest, ever been denied a license, permit or coregistration?	* *	Yes □ No ☒			
3)	Has the corporation, any owner(s), shareholder(s) or interest, ever been the subject of an administrative a site fine or proceeding relating to the pharmaceutical	ction, board citation,	Yes □ No ☒			
4)	Has the corporation, any owner(s), shareholder(s) or interest, ever been found guilty, pled guilty or entered contendere to any offense federal or state, related to substances?	d a plea of nolo	Yes □ No ☒			
5)	Has the corporation, any owner(s), shareholder(s) or interest, ever surrendered a license, permit or certific voluntarily or otherwise (other than upon voluntary cl	ate of registration	Yes □ No ☒			
Copie	answer to question 1 through 5 is "yes", a signed state s of any documents that identify the circumstance or o sition may be required.					
correc	by certify that the answers given in this application and the standerstand that any infraction of the laws of the stion of an authorized pharmacy may be grounds for the	State of Nevada regula	iting the			
I have read all questions, answers and statements and know the contents thereof. I hereby certifunder 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.						
Origin	al Signature of Person Authorized to Submit Applicati	on, no copies or stam	ps			
Tho	mas S. Moffatt, Vice President/Secretary	1-10-201	8			
Print	Name of Authorized Person	Date	Page 2			
Board	Use Only Date Processed:	Amount:				

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State	of Incorporation: Delaware	
Paren	t Company if any: Coram Specialty I	nfusion Services, LLC
Mailin	g Address: One CVS Drive	
City:	Woonsocket	tate: RI Zip: 02895
Telepl	hone: 401-770-6431	Fax: 401-216-0381
Conta	Vimborlay De Sousa	
	ny corporation non publicly traded, dis	close the following:
1)	List top 4 persons to whom the share	
		Inc. owns 100% of membership interest)
	Name	Address
	b)Name	Address
	ivanie	, ta 4. 333
	c)Name	Address
	d)Name	Address
2)	Provide the number of shares issue	by the corporation.
3)	What was the price paid per share?	
4)	What date did the corporation actua	lly receive the cash assets?
5)	Provide a copy of the corporation's	tock register evidencing the above information
l ist a	any physician shareholders and perce	ntage of ownership.
	• • -	%:
Name	e:	%:
Hour	rs of Operation for the pharmacy:	
Mono	day thru Friday <u>9</u> am <u>5</u> pı	
	Sundayamp	n 24 Hours on Call
A Ne	evada business license is not required se please provide the number: N/A	however if the pharmacy has a Nevada business

STATEMENT OF RESPONSIBILITY FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Inomas S. Monatt
Responsible Person of Coram Alternate Site Services, Inc., dba Coram CVS/specialty infusion service #4807
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 corporation.
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.
Original Signature of Person Authorized to Submit Application, no copies or stamps
Thomas S. Moffatt, Vice President/Secretary /-/0-30/8
Print Name of Authorized Person Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Arizona)
STATE OF Arizona) Maricopa COUNTY)
I, Amish Kapadia , hereby certify that the assertions in this Affidavit
are true and correct to the best of my knowledge and belief, and state as follows: Coram CVS/specialty infusion service #4807 for (the
Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.
2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile
products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-
of-State Pharmacy License.
3. I understand and acknowledge that the Pharmacy and any of its Nevada-
registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells
or ships any compounded sterile product into Nevada without first obtaining written authorization
from the Board to do so.
4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile
product into Nevada, the Pharmacy, through an authorized representative, will first notify the
Board and obtain written approval to sell and ship such products into Nevada.
5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile
product into Nevada, an authorized representative of the Pharmacy may be required to appear
before the Board to answer questions before such approval is granted.
FURTHER AFFIANT SAYETH NOT.
I, Amish Kapadia, do hereby swear under penalty of perjury that the assertions of this
affidavit are true.
Name SUBSCRIBED AND SWORN TO
before me, a notary public this 20 day of Vetember, 20 [7.]
NOTARY PUBLIC Notary Public - State of Artzone MARICOPA COUNTY My Commission Expires Aug. 10, 2021

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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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 Pharmacy or Ownership Chang e (Provide current license number if making changes: PH Check box below for type of ownership and complete all required forms.							
☐ Publicly Traded Corporation – Pages 1,2,3,7 ☐ Partnership - Pages 1,2,5,7 Non Publicly Traded Corporation – Pages 1,2,4,7 ☐ Sole Owner – Pages 1,2,6,7							
Non Publicly Trac	ded Corporation - Page:	s 1,2,4,7		Sole Owner – Pages 1,2,6,7			
GENERAL INFOR	MATION to be comp	leted by	y all types	s of ownership			
Pharmacy Name:	Coram Alternate Site So	ervices, l	Inc., dba Co	oram CVS/specialty infusion service #48090			
Physical Address:	12450 East Arapahoe	Road, Su	uite A1, Cer	ntennial, CO 80112			
Mailing Address:	One CVS Drive, MC #	1160		and the second s			
City: Woonsocket		State:		Zip Code:			
Telephone: 303-	799-0093	_Fax: _	303-790-06	533			
Toll Free Number:	800-934-0093		(Required	I per NAC 639.708)			
E-mail: statereply@	vevscaremark.com						
Managing Pharma	cist: Sherry Heinrichs	2		License Number: 16902			
	E OF PHARMACY		SE	RVICES PROVIDED			
Yes/I	No		Yes	s/No			
	□ Retail			☑ Off-site Cognitive Services			
	☑ Hospital (# beds	_)	X	☐ Parenteral **			
	☑ Internet		×	☐ Parenteral (outpatient)			
	Nuclear		X	☐ Outpatient/Discharge			
		Center		☑ Mail Service			
				☑ Long Term Care			
	🛮 Other:		. 🗵	☐ Sterile Compounding **			
				☑ Non Sterile Compounding			
All be	oxes must be checked						
Fort	he application to be сол	nplete		Other Services:			

^{**}If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within	the last five	(5) years:						
1)	any interest	poration, any owner(s), , ever been charged, or or (including by way of	convicted of a fe	lony or gross	Yes		No	X
2)	Has the cor any interest registration?	poration, any owner(s), , ever been denied a lic	shareholder(s) or ense, permit or c	r partner(s) with ertificate of	Yes		No	X
3)	interest, eve	poration, any owner(s), or been the subject of a proceeding relating to th	n administrative a	action, board citation,	Yes		No	X
4)	interest, eve	ooration, any owner(s), or been found guilty, ple to any offense federal o	d guilty or entere	d a plea of nolo	Yes		No	X
5)	interest, eve	ooration, any owner(s), r surrendered a license r otherwise (other than	, permit or certific	cate of registration	Yes		No	X
Copies	nswer to que s of any docu ition may be	estion 1 through 5 is "year siments that identify the required.	es", a signed state circumstance or e	ement of explanation n contain an order, agree	nust b ement	e,at :, or	tach oth	ned. er
correct	t. I understa	the answers given in the nd that any infraction of horized pharmacy may	f the laws of the S	State of Nevada regula	ting th		ue a	and
under (correct emplo)	penalty of pe :. I hereby a /ees, to cond	stions, answers and sta erjury, that the information athorize the Nevada Sta luct any investigation(s) cation and reputation, a	on furnished on that ate Board of Phar of the business,	his application are true rmacy, its agents, serv professional, social ar	, accu ants a nd mo	irate ind ral	cer an	tify, d
Origina	l Signature	of Person Authorized to	Submit Applicati	on, no copies or stamp	os			
		Vice President/Secretary		1-18-3018		_		
Print N	ame of Auth	orized Person		Date		Pag	ge 2	
Board \	Jse Only	Date Processed:		Amount: \$500,60)			

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

Stat	e of Incorporat	ion: Delaware					
Pare	ent Company if	any:					
iviali	ing Address;	Olic C V B DITVC					
City:	Woonsocket	770-6431	State:	RI	Zip:	02895	
Tele	phone:	770-6431 	F	ax: 4	01-216-0381		
Con	tact Person: _	Kimberley DeSou	sa ———	7			
Fora	any corporation	non publicly trac	ted disclose	the fell	outin au		
1)							
1)		rsons to whom th					
	a) N/A (Cora	m Alternate Site S			% of membersh	ip interest)	
		Name	Ac	dress			
	b)	Name					- S-2-2
		Name	Ac	ldress			
	c)	Name		dress			
	d)		Au	uress			
	d)	Name	Ad	dress			
2)	Provide the n	umber of shares			rī.		
		umber of shares					
3)	What was the	price paid per sl	nare?				
4)	What date did the corporation actually receive the cash assets?						
5)	Provide a copy of the corporation's stock register evidencing the above information						
List a		pareholders and p					
	: _N/A		arrachtago of	0111101	ornp.	07.5	
Name						%:	
1401110						%:	
Hours	of Operation	for the pharma	<u> </u>		Tare threat the		
Monda	ay thru Friday _	8_am _5	pm		Saturday	am	pm
	Sunday _	am	pm		24 Hours	oncall	Σ
A Nev	ada business li please provid	cense is not reque the number:	iired, howeve N/A	r if the	pharmacy has	a Nevada bu	siness
							Page 4

STATEMENT OF RESPONSIBILITY FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Thomas S. Moffatt	
Responsible Person of Coram Alternate Site Services,	Inc., dba Coram CVS/specialty infusion service #48090
hereby acknowledge and understand that in addition shareholder(s) or partner(s) responsibilities, may be rethat may occur in a pharmacy owned or operated by s	esponsible for any violations of pharmacy law
I further acknowledge and understand that the or partner(s)may be named in any action taken by the pharmacy owned by or operated by said corporation.	corporation's, any owner(s), shareholder(s) Nevada State Board of Pharmacy against a
I further acknowledge and understand that the or partner(s) cannot require or permit the pharmacist(s) of any local, state or federal laws or regulations pertain	s) in said pharmacy to violate any provision
May	
Original Signature of Person Authorized to Submit App	olication, no copies or stamps
Thomas S. Moffatt, Vice President/Secretary	1-18-2018
Print Name of Authorized Person	Dato

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Colorado)
STATE OF Colorado) ss. Arapahoe COUNTY)
I, Sherry Heinrichs , hereby certify that the assertions in this Affidavit
are true and correct to the best of my knowledge and belief, and state as follows: 1. I am the Pharmacist-In-Charge for (the
Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.
2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile
products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-
of-State Pharmacy License.
3. I understand and acknowledge that the Pharmacy and any of its Nevada-
registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells
or ships any compounded sterile product into Nevada without first obtaining written authorization
from the Board to do so.
4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile
product into Nevada, the Pharmacy, through an authorized representative, will first notify the
Board and obtain written approval to sell and ship such products into Nevada.
5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile
product into Nevada, an authorized representative of the Pharmacy may be required to appear
before the Board to answer questions before such approval is granted.
FURTHER AFFIANT SAYETH NOT.
I, Sherry Heinrichs , do hereby swear under penalty of perjury that the assertions of this
affidavit are true.
SUBSCRIBED AND SWORN TO before me, a notary public thisday of, 20
NOTARY PUBLIC

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane - Reno, NV 89509

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☐ Publicly Traded Corporation – Pages 1,2,3,7 ☐ Partnership - Pages 1,2,4,7 ☐ Sole Owner – Pages 1,	2,6,7				
GENERAL INFORMATION to be completed by all types of ownership					
Pharmacy Name: PROMISE Pharmacy					
Physical Address: 318 18 US Hay 19 N					
Mailing Address:					
City: Palm Harbor State: Fl Zip Code:	34684				
Telephone: $\frac{727-772-0500}{}$ Fax: $\frac{727-772-0511}{}$					
Toll Free Number: 888 3ワームサラ (Required per NAC 639.708)					
E-mail: 1060 @ Promise phanonary. Con Website: www Promise P	harmacy. Com				
Managing Pharmacist: JIYANG Chung License Number	r: 51110				
TYPE OF PHARMACY AND SERVICES PROVIDED					
Yes/No Yes/No					
☑ □ Retail □ ☒ Off-site Cognitive	Services				
	Services				
☑ □ Retail □ ☒ Off-site Cognitive					
☐ Retail ☐ ဩ Off-site Cognitive ☐ ဩ Hospital (# beds) ☐ ဩ Parenteral **	ient)				
☐ Retail ☐ ☐ ☐ Off-site Cognitive ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ient)				
☐ Retail ☐ ☐ Off-site Cognitive ☐ ☐ ☐ Parenteral ** ☐ ☐ Internet ☐ ☐ Parenteral ** ☐ ☐ Nuclear ☐ ☐ Outpatient/Dischar ☐ ☐ Ambulatory Surgery Center ☐ Mail Service ☐ ☐ Community ☐ ☐ Long Term Care	ient) rge				
☐ Retail ☐ ☐ Off-site Cognitive ☐ ☐ Parenteral ** ☐ ☐ Hospital (# beds) ☐ ☐ Parenteral ** ☐ ☐ Nuclear ☐ ☐ Outpatient/Dischal ☐ ☐ Ambulatory Surgery Center ☐ Mail Service	ient) rge				
☐ Retail ☐ M Hospital (# beds) ☐ N Parenteral ** ☐ Nuclear ☐ M Ambulatory Surgery Center ☐ M Community ☐ M Compound ☐ Non Sterile Compound	ient) rge ing ** punding				
☐ Retail ☐ ☐ Off-site Cognitive ☐ ☐ ☐ Parenteral ** ☐ ☐ ☐ Hospital (# beds) ☐ ☐ Parenteral ** ☐ ☐ ☐ Nuclear ☐ ☐ Outpatient/Dischare ☐ ☐ Ambulatory Surgery Center ☐ ☐ Mail Service ☐ ☐ Community ☐ ☐ Long Term Care ☐ ☐ Other: ☐ Sterile Compound	ient) rge ing ** bunding e Compounding **				

^{**}If you check "yes" on any of these types of services, you will be <u>required</u> to make an appearance at the board meeting,

APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within	the last five (5) years:			
1)	Has the corporation, any own any interest, ever been charge misdemeanor (including by was a second control of the corporation).	ged, or convicted of a fel	ony or gross	Yes □ No 🏿
2)	Has the corporation, any own any interest, ever been denied registration?			Yes □ No ⊠
3)	Has the corporation, any own interest, ever been the subjective site fine or proceeding relations.	ct of an administrative a	ction, board citation,	Yes □ No 🏖
4)	Has the corporation, any own interest, ever been found gui contendere to any offense fe substances?	lty, pled guilty or entered	d a plea of nolo	Yes □ No 內
5)	Has the corporation, any owr interest, ever surrendered a l voluntarily or otherwise (other	icense, permit or certific	ate of registration	Yes □ No 점
If the answer to question 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.				
Origina	al Signature of Person Author	ized to Submit Application	on, no copies or stamp	 S
(PRAIG Bachlor		17/14/12	
Print N	lame of Authorized Person		Date	
				Page 2
Board	Use Only Date Processed:	·	Amount: <u>\$ 500.00</u>	·

STATEMENT OF RESPONSIBILITY FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

1, KIKK PATEL				
Responsible Person of Promise Pharman				
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 corporation.				
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.				
Original Signature of Person Authorized to Submit Application, no copies or stamps				
Print Name of Authorized Person 12 15 2017 Date				

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General	Limited <u>~</u>
Partnership Name: The Romine Pharma	cy LLC
Mailing Address: <u>318 18 05 19 N</u>	J
City: Palm Han Bon State: Fl Zip Coo	de: <u>3 4684</u>
Telephone Number: 727-772.0500 Fax Number: 727	
Contact Person: CRAIS BACHIER	
List each partner and identify whether (G)eneral or (L)imited partner at Use separate sheet if necessary	
<u>Name</u>	or L Percentage
Dipti RATEL 3190 HAMBlin WAS	
Digti Ratel 3190 HAMBlin way	G 10070
List names of 4 largest partners and percentage of ownership:	
Name: Digti PATel	<u> </u>
Name:	%:
Name:	
Name:	<u></u> %:
List any physician shareholders and percentage of ownership.	
Name: Name:	%:
Name:	%:
Name:	
Hours of Operation for the pharmacy:	
Monday thru Friday _ am _ <u>ெ.்.y</u> pm Saturday	ampm
Sundayampm 24 Hours	•
A Nevada business license is not required, however if the pharmacy h license please provide the number:	as a Nevada business

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Celeste Philip, MD, MPH

Surgeon General and Secretary

Vision: To be the Healthiest State in the Nation

December 4, 2017

Promise Pharmacy Attn: Jacki Thibodeau 31818 US Hwy 19N Palm Harbor, Fl 34684

RE: License Certification for Promise Pharmacy, LLC

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:

Pharmacy

LICENSE NUMBER:

PH22007

ORIGINAL CERTIFICATION:

05/16/2006

EXPIRATION DATE:

02/28/2019

CURRENT STATUS OF LICENSE:

CLEAR.

AGENCY ACTION:

No

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595, option 5.

Sincerely

Tiquitta Floyd

Regulatory Specialist II





License Number: PH22007

Data As Of 12/14/2017

Profession

License

License Status

Qualifications

License Expiration Date

Address of Record

License Original Issue Date

Controlled Substance Prescriber (for the Treatment of Chronic Non-

malignant Pain)

Discipline on File

Public Complaint

Pharmacy

PH22007

CLEAR/

Schedule II & Community Pharmacy

2/28/2019

05/16/2006

31818 US 19

PALM HARBOR, FL

34684

No

No

No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.