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 ☒ ***Ownership Change*** *(Provide current license number if making changes:* **PH** 01778

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*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Coram Alternate Site Services, Inc. dba: Coram CVS/specialty Infusion Services

Physical Address: 4601 E. Hilton Ave., Ste. 105, Phoenix, AZ 85034

Mailing Address: One CVS Drive, Licensing Dept/MC 1160

City: Woonsocket State: RI Zip Code: 02895

Telephone: 480-240-3209 Fax: 480-505-0455

Toll Free Number: _____ (Required per NAC 639.708)

E-mail: kimberly.mitchell@cvshealth.com Website: 800-697-1667

Managing Pharmacist: Richard Monty License Number: 508661

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☑	☐ Parenteral **
☐	☑ Internet	☑	☐ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☑	☐ Community	☐	☑ Long Term Care
☑	☐ Other: Non-Resident	☑	☐ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☑	☐ Mail Service Sterile Compounding **
	For the application to be complete	☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

99606

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 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, board citation, site fine 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 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Thomas S. Moffatt
Print Name of Authorized Person

1/31/2018
Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Coram Specialty Infusion Services, L.L.C.

Mailing Address: One CVS Drive

City: Woonsocket State: RI Zip: 02895

Telephone: 401-770-6431 Fax: 401-216-0381

Contact Person: Kimberley DeSousa

For any corporation non publicly traded, disclose the following:

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

a) N/A (Coram Specialty Infusion Services, L.L.C. owns 100% of membership interest)
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. _____

3) What was the price paid per share? _____

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 any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 5 pm Saturday No am _____ pm

Sunday No am _____ pm 24 Hours No

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

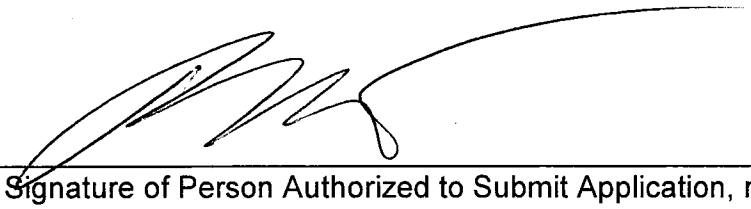
I, Thomas S. Moffatt

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 — 1/31/2018

Print Name of Authorized Person — Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Arizona)
) 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 Coram Alternate Site Services, Inc. dba Coram CVS/Specialty Infusion Services (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, Richard Monty do hereby swear under penalty of perjury that the assertions of this affidavit are true.

X _____
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
29 day of January, 2018.

Kirstin A. Thoner
NOTARY PUBLIC

KIRSTIN A THONER
Notary Public - Arizona
Maricopa County
My Comm. Expires Dec 21, 2019

Revised

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

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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 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*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Coram Alternate Site Services, Inc., dba Coram CVS/specialty infusion service #48078

Physical Address: 4310 East Cotton Center Blvd, Suite 110, Phoenix, AZ 85040

Mailing Address: One CVS Drive, MC #1160

City: Woonsocket State: RI Zip Code: 02895

Telephone: 602-438-7888 Fax: 602-438-4559

Toll Free Number: 800-530-1199 (Required per NAC 639.708)

E-mail: statereply@cvscaremark.com Website: _____

Managing Pharmacist: Amish Kapadia License Number: S021813

TYPE OF PHARMACY AND **SERVICES PROVIDED**

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☒ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☒	☐ Parenteral **
☐	☒ Internet	☒	☐ Parenteral (outpatient)
☐	☒ Nuclear	☒	☐ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☐	☒ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☒	☐ Other: Home Infusion	☒	☐ Sterile Compounding **
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☒	☐ Mail Service Sterile Compounding **
	For the 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 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, board citation, site fine 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 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Thomas S. Moffatt, Vice President/Secretary

Print Name of Authorized Person

1-10-2018

Date

Board Use Only Date Processed: _____ Amount: _____

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Coram Specialty Infusion Services, LLC

Mailing Address: One CVS Drive

City: Woonsocket State: RI Zip: 02895

Telephone: 401-770-6431 Fax: 401-216-0381

Contact Person: Kimberley DeSousa

For any corporation non publicly traded, disclose the following:

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

a) N/A (Coram Alternate Site Services, Inc. owns 100% of membership interest)
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. _____

3) What was the price paid per share? _____

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 any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours on Call

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

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 #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
Print Name of Authorized Person

1-10-2018
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Arizona)
) ss.
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:

1. I am the Pharmacist-In-Charge for Coram CVS/specialty infusion service #48078 (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 December, 2017.

NOTARY PUBLIC

ITZEL SARAY NIETO
Notary Public - State of Arizona
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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☒ *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*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Coram Alternate Site Services, Inc., dba Coram CVS/specialty infusion service #48090

Physical Address: 12450 East Arapahoe Road, Suite A1, Centennial, CO 80112

Mailing Address: One CVS Drive, MC #1160

City: Woonsocket State: RI Zip Code: 02895

Telephone: 303-799-0093 Fax: 303-790-0633

Toll Free Number: 800-934-0093 (Required per NAC 639.708)

E-mail: statereply@cvscaremark.com Website: _____

Managing Pharmacist: Sherry Heinrichs License Number: 16902

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☒	☐ Parenteral **
☐	☒ Internet	☒	☐ Parenteral (outpatient)
☐	☒ Nuclear	☒	☐ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☐	☒ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☒	☐ Sterile Compounding **
		☐	☒ Non Sterile Compounding
	All boxes must be checked	☒	☐ Mail Service Sterile Compounding **
	For the 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,**

99665

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 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, board citation, site fine 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 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.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Thomas S. Moffatt, Vice President/Secretary

Print Name of Authorized Person

1-18-2018

Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: _____

Mailing Address: One CVS Drive

City: Woonsocket State: RI Zip: 02895

Telephone: 401-770-6431 Fax: 401-216-0381

Contact Person: Kimberley DeSousa

For any corporation non publicly traded, disclose the following:

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

a) N/A (Coram Alternate Site Services, Inc., owns 100% of membership interest)
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. _____

3) What was the price paid per share? _____

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 any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 5 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours on call

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: N/A

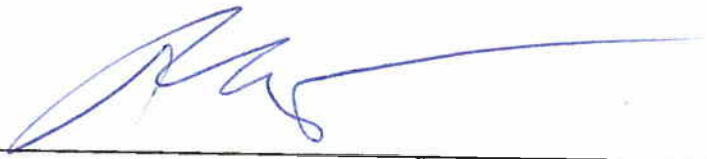
STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

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 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

Print Name of Authorized Person

1-18-2018

Date

N/A

AFFIDAVIT for Out-of-State Pharmacy License

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 Coram CVS/specialty infusion service #48090 (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.

_____
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
___day of _____, 20___.

_____
NOTARY PUBLIC

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☐ *Non Publicly Traded Corporation – 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: 3118 US Hwy 19 N

Mailing Address: _____

City: Palm Harbor State: FL Zip Code: 34684

Telephone: 727-772-0500 Fax: 727-772-0511

Toll Free Number: 888 377-6647 (Required per NAC 639.708)

E-mail: info@promisepharmacy.com Website: www.promisepharmacy.com

Managing Pharmacist: Jiyang Chung License Number: 5110

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☒ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral **
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☒	☐ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☒	☐ Sterile Compounding **
		☒	☐ Non Sterile Compounding
	All boxes must be checked	☐	☒ Mail Service Sterile Compounding **
	For the 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

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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, board citation, site fine 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 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.

Craig Bachler
Original Signature of Person Authorized to Submit Application, no copies or stamps

CRAIG Bachler
Print Name of Authorized Person

12/14/12
Date

Board Use Only Date Processed: _____ Amount: $500.00

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Rikk Patel

Responsible Person of Promise Pharmacy

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

Rikk Patel
Print Name of Authorized Person

12/15/2017
Date

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General ____ Limited ✓

Partnership Name: ~~N/A~~ PROMISE PHARMACY LLC

Mailing Address: 3818 US 19 N

City: Palm Harbor State: FL Zip Code: 34684

Telephone Number: 727-772-0500 Fax Number: 727-772-0511

Contact Person: CRAIG BACHLER

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

Name	G or L	Percentage
Dipti Patel 3190 Hamblin Way		
Wellington FL 33414	G	100%

List names of 4 largest partners and percentage of ownership:

Name: Dipti Patel %: 100%

Name: ____ %: ____

Name: ____ %: ____

Name: ____ %: ____

List any physician shareholders and percentage of ownership.

Name: N/A %: 0

Name: ____ %: ____

Name: ____ %: ____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6:30 pm Saturday ____ am ____ pm

Sunday ____ am ____ pm 24 Hours ____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: ____

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

/TF

Department of Health

License Number: PH22007

Data As Of 12/14/2017

Profession	Pharmacy
License	PH22007
License Status	CLEAR/
Qualifications	Community Pharmacy Schedule II & III
License Expiration Date	2/28/2019
License Original Issue Date	05/16/2006
Address of Record	31818 US 19 PALM HARBOR, FL 34684
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	No
Discipline on File	No
Public Complaint	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.