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 or ☒ Ownership Change (Provide current license number if making changes: PH____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Direct Compounding, LLC

Physical Address: 1850 Whitney Mesa Dr, Suite 180

City: Henderson State: NV Zip Code: 89014

Telephone: 702-877-0703 Fax: 702-342-0335

Toll Free Number: 888-341-0157 E-mail: egerber@directcompounding.com

Website: _____

Managing Pharmacist: Tim Brown License Number: 13529

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: Compounding	☐	☐ Sterile Compounding
		☐	☐ Non Sterile Compounding
	All boxes must be checked	☐	☐ Mail Service Sterile Compounding
	For the application to be complete	☐	☐ Other Services: _____

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, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

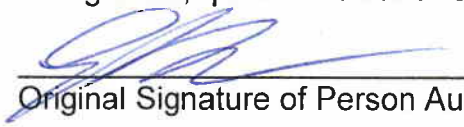
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Ellie Gelber
Print Name of Authorized Person

2/4/2018
Date

Board Use Only	Date Processed: _____	Amount: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: - NA -

Mailing Address: 1850 Whitney Mesa Dr, Suite 180

City: Henderson State: NV Zip: 89014

Telephone: 702-877-0703 Fax: 702-342-0335

Contact Person: Elie Gerber or Timothy Brown

For any corporation non publicly traded, disclose the following:

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

a) Alicia Smith 1850 Whitney Mesa Dr, Suite 180 Henderson NV 89014
Name Business Address

b) Ellie Gerber 1850 Whitney Mesa Dr, Suite 180, Henderson NV 89014
Name Business Address

c) David Smith 1850 Whitney Mesa Dr, Suite 180, Henderson NV 89014
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. 300

3) What was the price paid per share? $ PAR VALUE

List any physician shareholders and percentage of ownership.

Name: David Smith %: 10%

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 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: _____

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

I, David J Smith

Responsible Person of Direct Compounding and Outsourcing 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.

David J Smith

Original Signature, no stamps or copies

11/8/2017

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Timothy Brown License #: 13529

Pharmacy Name: Direct Compounding

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 Date: 2011 Case #: 11-092C-RPH-S

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Original Signature, no stamps or copies

10/4/2017
Date

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 or ☐ Ownership Change (Provide current license number if making changes: PH____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b ☐ Partnership - Pages 1,2,6,10,11a&b

☑ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b ☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Goodwill Pharmacy, Inc.

Physical Address: 6725 S. Eastern Ave, Unit 7

City: Las Vegas State: NV Zip Code: 89119

Telephone: 702-560-2679 Fax: 702-940-7580

Toll Free Number: n/a E-mail: ut1east@gmail.com

Website: n/a

Managing Pharmacist: Christopher Vu Vuong License Number: 18821

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☒	☐ 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: _____

99853

APPLICATION FOR NEVADA 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.

M:

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

Arun Pasricha — Print Name of Authorized Person

02/04/2018 — Date

Board Use Only Date Processed: _____ 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

Mailing Address: 6725 S. Eastern Ave, Unit 7

City: Las Vegas State: NV Zip: 89119

Telephone: 702-560-2679 Fax: 702-940-7580

Contact Person: Arun Pasricha

For any corporation non publicly traded, disclose the following:

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

a) Arun Pasricha 11711 Cochise Pl. Chatsworth, CA 91311
Name Business Address

b) N/A
Name Business Address

c) N/A
Name Business Address

d) N/A
Name Business Address

2) Provide the number of shares issued by the corporation. 1

3) What was the price paid per share? 100

List any physician shareholders and percentage of ownership.

Name: N/A %:

Name: N/A %:

Hours of Operation for the pharmacy:

Monday thru Friday 10 am 6 pm Saturday N/A am N/A pm

Sunday N/A am N/A pm 24 Hours N/A

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 – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, Arun Pasricha

Responsible Person of Goodwill Pharmacy, Inc.

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

Arun Pasricha
Print Name of Authorized Person

02/04/2018
Date

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA 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. **If LLC use Non Public Corporation or Partnership.

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☐ Partnership - Pages 1,2,6,10,11a&b
☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: SANTA MARIA PHARMACY

Physical Address: 3827 E SUNSET ROAD UNIT L

City: LAS VEGAS State: NV Zip Code: 89120

Telephone: 702-741-3735 Fax: _____

Toll Free Number: _____ E-mail: _____

Website: _____

Managing Pharmacist: MICHAEL SOLMAN License Number: 58183

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☒	☐ 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: _____

9984

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, 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.

Michael Soliman

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

MICHAEL SOLIMAN — Print Name of Authorized Person

1-23-18 — Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: GUADALUPE PHARMACY INC

Mailing Address: 3827 E SUNSET ROAD UNIT L

City: LAS VEGAS State: NV Zip: 89120

Telephone: 702-741-3735 Fax: _____

Contact Person: MICHAEL SOLIMAN

For any corporation non publicly traded, disclose the following:

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

a) MICHAEL SOLIMAN 3827 E SUNSET RD UNIL L LAS VEGAS, NV 89120
Name Business Address

b) _____
Name Business Adoress

c) _____
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. $5,000

3) What was the price paid per share? _____ $1.00

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9:30 am 6:00 pm Saturday X am X pm

Sunday X am X pm 24 Hours X

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20161584135

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, MICHAEL SOLIMAN

Responsible Person of GUADALUPE PHARMACY INC.

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.

Michael Soliman

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

MICHAEL SOLIMAN — 1-23-18

Print Name of Authorized Person — Date

Managing Pharmacist

Pharmacist Name: MICHAEL SOLIMAN License #: 16466/58183

Pharmacy Name: SANTA MARIA PHARMACY

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 a board citation or 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: _____

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

Signature _____ Date 1-23-18