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 currer Check box below for type of ownership and complete all re Corporation or Partnership.	nt license number if making changes: PH equired forms. **If LLC use Non Public					
☐ 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&						
GENERAL INFORMATION to be completed by all to	ypes of ownership					
Pharmacy Name: Pirect Compounding 1						
Physical Address: 1850 Whitney Mesa De	Suite 180					
City: Henderson State: N						
Telephone: 102-817-0703 Fax: 102-	-342-0335					
Toll Free Number: <u>888-341-0157</u> E-mai	legerbere direct compounding con					
Website:						
Managing Pharmacist: Tim Brown License Number: 13529						
TYPE OF PHARMACY AND	SERVICES PROVIDED					
Yes/No	Yes/No					
y⊒⊄ □ Retail	☐ ☐ Off-site Cognitive Services					
☐ ☐ Hospital (# beds)	□ □ Parenteral					
□ □ Internet	□ □ Parenteral (outpatient)					
□ □ Nuclear	□ □ Outpatient/Discharge					
☐ ☐ Ambulatory Surgery Center	☐ ☐ Mail Service					
□ □ Community	☐ ☐ Long Term Care					
D Other: Campundry	□ □ Sterile Compounding					
	□ □ Non Sterile Compounding					
All boxes must be checked	☐ ☐ Mail Service Sterile Compounding					
For the application to be complete	☐ ☐ Other Services:					
	Name of the second seco					

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 🗖
Copie	answer to question 1 through 5 is "yes", a signed statement of explanation mess of any documents that identify the circumstance or contain an order, agreestition may be required.	
correc	by certify that the answers given in this application and attached documental t. I understand that any infraction of the laws of the State of Nevada regulat tion of an authorized pharmacy may be grounds for the revocation of this pe	ing the
under correc emplo	read all questions, answers and statements and know the contents thereof. penalty of perjury, that the information furnished on this application are true, it. I hereby authorize the Nevada State Board of Pharmacy, its agents, servayees, to conduct any investigation(s) of the business, professional, social arround, qualification and reputation, as it may deem necessary, proper or described.	accurate and ants and do moral
Origin	al Signature of Person Authorized to Submit Application, no copies or stamp	S
	Vame of Authorized Person Date	
Poard	Use Only Date Processed: Amount	

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation:
Parent Company if any:NA
Mailing Address: 1850 Whitney Mesa DK, Svite 180
City: Henderson State: NV Zip: 89014
Telephone: 702-877-0703 Fax: <u>702-342-0335</u>
Contact Person: Blie Geber or Tmothy 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 Dz. Sutte 180 Name Business Address Henderson NV 89014
b) Elic Geber 1850 Whitney Mesa De Suite 180, Henderson NV Name Business Address 8901
c) David South 1850 Whitney Mean Dr. Sutte 180, Henderson NV Name Business Address 8901
d) Name Business Address
2) Provide the number of shares issued by the corporation. <u>300</u>
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 Fridayampm Saturdayampm
Sundayampm 24 Hours
A Nevada business license is not required, however if the pharmacy has a Nevada business

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

Responsible Person of Direct Compounding and outsour of
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 1/8/2017 Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name:	License #: <u>/3</u>	529	
Pharmacist Name: Timothy Brown Pharmacy Name: Direct Compounding			
As a managing pharmacist of the above referenced pharmacy, I understal report for duty as the managing pharmacist, I shall cause an inventory of all control pharmacy according to the method prescribed by the provision of 21 CFR Part 13 the inventory to be on file at the pharmacy.	rolled substanc	es of th	ne
I understand that as the managing pharmacist I am responsible for compliand its personnel with all state and federal laws and regulations relating to the open and the practice of pharmacy. I understand my license can be revoked or that I disciplinary action if such laws or regulations are knowingly violated in the pharmanaging pharmacist.	peration of the local	pharma	
I understand that if I cease to be managing pharmacist of the above name	ed pharmacy I v	will join	4ls z
with the new managing pharmacist, take an inventory of all controlled substances			uy,
with the new managing pharmacist, take an inventory of all controlled substances Been diagnosed or treated for any mental illness, including alcohol or substance physical condition that would impair your ability to perform the essential functions	abuse, or	Yes e? □	No
Been diagnosed or treated for any mental illness, including alcohol or substance	abuse, or s of your license		No
Been diagnosed or treated for any mental illness, including alcohol or substance physical condition that would impair your ability to perform the essential functions 1. been charged, arrested or convicted of a felony or misdemeanor in any state?	abuse, or s of your license		No
Been diagnosed or treated for any mental illness, including alcohol or substance physical condition that would impair your ability to perform the essential functions 1. been charged, arrested or convicted of a felony or misdemeanor in any state?	abuse, or s of your license		No
Been diagnosed or treated for any mental illness, including alcohol or substance physical condition that would impair your ability to perform the essential functions 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 3. had your license subjected to any discipline for violation of pharmacy or drug	abuse, or sof your license on any state?	e? 🗆	No P
Been diagnosed or treated for any mental illness, including alcohol or substance physical condition that would impair your ability to perform the essential functions 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 3. had your license subjected to any discipline for violation of pharmacy or drug state?	abuse, or sof your license any state? laws in any	e? □	No P

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

Date

10/4/2017

NEVADA STATE BOARD OF PHARMACY

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New Pharmacy or ☐ Ownership Change (Provide Check box below for type of ownership and complete Corporation or Partnership. ☐ Publicly Traded Corporation — Pages 1,2,3,10,11a	all required forms. **If LLC use Non Public				
GENERAL INFORMATION to be completed by					
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	-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				
□ ៨ Hospital (# beds)	□ ဩ Parenteral				
□ 🖾 Internet	□ 図 Parenteral (outpatient)				
☐ 🖾 Nuclear	□ 🗵 Outpatient/Discharge				
☐ ☑ Ambulatory Surgery Center	🖸 🔯 Mail Service				
□ □ Community	☐ 🖾 Long Term Care				
□	□ ☑ Sterile Compounding				
	□ 🖾 Non Sterile Compounding				
All boxes must be checked					
All boxes must be checked	☐ ☑ Mail Service Sterile Compounding				
All boxes must be checked For the application to be complete	☐ ☑ Mail Service Sterile Compounding ☐ ☑ Other Services:				

This page must be submitted for all types of ownership.

Withir	n the last five (5) years:				
1)	Has the corporation, any owner(s), shareholder(s) or any interest, ever been charged, or convicted of a fe misdemeanor (including by way of a guilty plea or no	lony or gross	Yes □	No 🛭	X
2)	Has the corporation, any owner(s), shareholder(s) or any interest, ever been denied a license, permit or ce registration?	partner(s) with ertificate of	Yes □	No 2	₹]
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 □ I	No [2	<u> </u>
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?	a plea of nolo	Yes □ !	No D	₹
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 class).	ate of registration	Yes □ I	No 🗵	<u>(</u>
Copies	answer to question 1 through 5 is "yes", a signed state s of any documents that identify the circumstance or californ may be required.	ement of explanation m contain an order, agree	ust be attement, or	tache other	d
correc	by certify that the answers given in this application and t. I understand that any infraction of the laws of the S ion of an authorized pharmacy may be grounds for th	tate of Nevada regulat	ing the	ue ar	ıd
under correct employ	read all questions, answers and statements and know penalty of perjury, that the information furnished on that. I hereby authorize the Nevada State Board of Phar yees, to conduct any investigation(s) of the business, round, qualification and reputation, as it may deem ne	iis application are true, macy, its agents, serva professional, social an	accurate ants and d moral	certing and	fy
Origina	al Signature of Person Authorized to Submit Application	n no conice aviatana			
			S		
	Pasricha Iame of Authorized Person	02/04/2018 Date			
Board	Use Only Date Processed:	Amount: 500,00			-

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, disclos	e the following:
1) List top 4 persons to whom the shares we	ere issued by the corporation?
a) Arun Pasricha 11711 Cochise Pl	Chatsworth, CA 91311
	Business Address
b) N/A	
Name	Business Address
c)N/A	Duction Address
	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? $\frac{100}{100}$)
List any physician shareholders and percentage	e of ownership.
Name: N/A	%:
Name: Name:	%:
Hours of Operation for the pharmacy:	
Monday thru Friday 10 am 6 pm	Saturday N/A am N/A pm
Sunday <u>N/A</u> am <u>N/A</u> pm	24 Hours N/A
A Nevada business license is not required, how license please provide the number: N/A	ever if the pharmacy has a Nevada business

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 additi	on to the corporation's, any owner(s),
shareholder(s) or partner(s) responsibilities, may be	pe responsible for any violations of pharmacy la
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	on.
I further acknowledge and understand that	the corporation's, any owner(s), shareholder(s)
or partner(s) cannot require or permit the pharmac	cist(s) in said pharmacy to violate any provision
of any local, state or federal laws or regulations pe	ertaining to the practice of pharmacy.
M:	
Original Signature of Person Authorized to Submit	Application, no copies or stamps
Arun Pasricha	02/04/2018
Print Name of Authorized Person	Date

NEVADA STATE BOARD OF PHARMACY

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Check box below for type of ownership and complete all re Corporation or Partnership. ☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b ☑ Non Publicly Traded Corporation – Pages 1,2,4,10,11a	☐ Partnership - Pages 1,2,6,10,11a&b a&b ☐ Sole Owner – Pages 1,2,8,10,11a&b
GENERAL INFORMATION to be completed by all	
Pharmacy Name: SANTA MARIA	
Physical Address: 3827 E SUNS	ET ROAD UNITL
City: LAS VEGAS State:	NV Zip Code: 89120
Telephone: 702 - 741 - 3785Fax:	Control Control of the Control of the Section of th
Toll Free Number:E-ma	ili.
Website:	
Managing Pharmacist: MICHAEL SO	HMAWLicense Number: 58183
TYPE OF PHARMACY AND	SERVICES PROVIDED
TYPE OF PHARMACY AND Yes/No	SERVICES PROVIDED Yes/No
	Selection of the select
Yes/No	Yes/No
Yes/No	Yes/No C Ø Off-site Cognitive Services
Yes/No Petail Netail Hospital (# beds)	Yes/No ☐ Ø Off-site Cognitive Services □ Ø Parenteral
Yes/No ☐ Retail ☐ Hospital (# beds) ☐ Internet	Yes/No ☐ Ø Off-site Cognitive Services ☐ Ø Parenteral ☐ Ø Parenteral (outpatient)
Yes/No ☐ Retail ☐ Hospital (# beds) ☐ Internet ☐ Nuclear	Yes/No ☐ Ø Off-site Cognitive Services ☐ Ø Parenteral ☐ Ø Parenteral (outpatient) ☐ Ø Outpatient/Discharge
Yes/No Retail Hospital (# beds) Internet Nuclear Ambulatory Surgery Center	Yes/No ☐ Ø Off-site Cognitive Services ☐ ☐ Parenteral ☐ ☑ Parenteral (outpatient) ☐ ☑ Outpatient/Discharge ☐ ☑ Mail Service
Yes/No Retail Hospital (# beds) Internet Nuclear Ambulatory Surgery Center Community	Yes/No ☐ Ø Off-site Cognitive Services ☐ Ø Parenteral ☐ Ø Parenteral (outpatient) ☐ Ø Outpatient/Discharge ☐ Ø Mail Service ☐ Ø Long Term Care
Yes/No Retail Hospital (# beds) Internet Nuclear Ambulatory Surgery Center Community	Yes/No ☐ Ø Off-site Cognitive Services ☐ Parenteral ☐ Parenteral (outpatient) ☐ Ø Outpatient/Discharge ☐ Ø Mail Service ☐ Ø Long Term Care ☐ Ø Sterile Compounding
Yes/No Retail Hospital (# beds) Internet Nuclear Ambulatory Surgery Center Community Other:	Yes/No ☐ ☑ Off-site Cognitive Services ☐ ☐ Parenteral ☐ ☐ Parenteral (outpatient) ☐ ☐ Outpatient/Discharge ☐ ☑ Mail Service ☐ ☑ Long Term Care ☐ ☑ Sterile Compounding ☑ Non Sterile Compounding

This page must be submitted for all types of ownership.

	The state of owners my	
Withir	n 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?	<i>-</i>
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 🗖 🦳
Copie	answer to question 1 through 5 is "yes", a signed statement of explanation s of any documents that identify the circumstance or contain an order, ag sition may be required	n must be attached. reement, or other
correc	by certify that the answers given in this application and attached document. I understand that any infraction of the laws of the State of Nevada regulation of an authorized pharmacy may be grounds for the revocation of this	ulating the
under correc emplo backg	e read all questions answers and statements and know the contents there penalty of perjury, that the information furnished on this application are trot. Thereby authorize the Nevada State Board of Pharmacy, its agents, services to conduct any investigation(s) of the business, professional, social pround, qualification and reputation, as it may deem necessary proper or a conduct and provided the provi	ue, accurate and ervants and and moral desirable.
Origin	al Signature of Person Authorized to Submit Application, no copies or sta	mps
	MICHAEL BOLIMAN 1-23.	-18
Print I	Name of Authorized Person Date	
Board	Use Only Date Processed: Amount:	.00

<u>OW</u>	NERSHIP IS	A NON PUBLI	CY TRADED	CORPORATIO	<u>N</u>			_
State	e of Incorpora	ation:	NEVA	DA				
Pare	nt Company	if any:G	UADAL	UPE PI	4ARMAC	CUINC	-	
Maili	ng Address:	3827	E SU	WSET ,	ROAD	UNIT L		
City:	LAS	VECA	Star	te: NV	Zip:	39120		
Tele	ohone:	02-74	1-3725	Fax:				
Cont	act Person:	MICH	AEL .	Fax: SOLIMAI	$\mathcal{O}_{\underline{}}$			
				ose the followin				
1)	List top 4 p	ersons to who	m the shares	were issued by	the corpora	tion?		
							ED ONI	LL
	/	Name		AN 386 Business Addre	ss LA	& VEGA	KS,N.	1/8912
	b)							
				Business Addre	:\$\$			
	c)			Business Addre				
		Name		Business Addre	98 8			
	d)	Name		Business Addre				
						a A		
2)	Provide the	e number of sh	ares issued b	y the corporatio	in. \$3,	800		
3)	What was	the price paid	per share? _		<u> </u>	\$ 1.00		
l ist a	any physiciar	; shareholders	and nercenta	ge of ownership	à			
						%:		
		ion for the ph				•		
Mon	dav thru Frid	ay <u>9:30 a</u> m	6:0 pm		Saturday	× am	X pi	m
		X am			24 Hours	*		
A Ne	evada busine	ss license is no	ot required, ho	owever if the ph			siness	

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

I, ____YICHAEL 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.
$m = n \cap n$
lichaellallan
Original Signature of Person Authorized to Submit Application, no copies or stamps
(1 1 1 2 1 S)//// An/ 1 22 15
MICHAEL SOLIMAN 1-23-18
Print Name of Authorized Person Date

Managing Pharmacist

 Pharmacist Name:	MICHA	EL SOL	-IMAN	License #:	16466/58183
Pharmacy Name:	SANTA	MARIA	PHARM		,

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.

	es	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?		X				
been charged, arrested or convicted of a felony or misdemeanor in any state?						
been the subject of a board citation or an administrative action whether completed or pending in any state?						
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		-				

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

1-23-18

Date