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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$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 MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW)
☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6 ☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7 Please check box for type of ownership and complete correct part of the application.
GENERAL INFORMATION to be completed by all types of ownership
MDEG Name: All time Health care
Physical Address: 4660 S. Easfan Ave Ste # 100 LV NV 89119 (This must be a business address, we can not issue a license to a home address)
Mailing Address: 4660 S. Eastern Ave Ste # 100
City: State: _W Zip Code:
Telephone: 402-480-5617 Fax:
E-mail: <u>all-time healtheare@gmail.com</u> Website:
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: <u>Pan to SPM</u> Tue: <u>Pan to SPM</u> Wed: <u>Pan to SPM</u> Thu: <u>Pan to SPM</u> Fri: <u>Pan to SPM</u> Sat: <u>Pan to SPM</u> Sun: <u>Avecl</u> Holidays: to
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Angelica Gutierrez
Number of the first of the firs
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
☐ Medical Gases** ☐ Respiratory Equipment** ☐ Life-sustaining equipment** ☐ Diabetic Supplies Assistive Equipment ☐ Parenteral and Enteral Equipment** ☐ Orthotics and Prosethics ☐ Other: Inconfinence of disposable supplies **If providing these types of partices you are required to have in place a mechanism to ensure
**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Telephone: Page 1

This page must be submitted for all types of ownership.

List	all Medicare and Medicaid p	provider numb	ers regis	tered to the business or it	ts owner	•
	Medicare 11	1 phouss				
j	Hedicaid 1	n process				
1)	Do any shareholders hold any type of business or fa or another political jurisdi	acility which a	ownership re license	or have management in ed by the State of Nevada	Yes □	No Ø
2)	Are you or have you in th business or health care e dispensed or distributed?	ntity in which	en assoc MDEG p	iated with any person, roducts were sold,	Yes □	No 12
3)	Are any of the owners he	alth professio	nals? If y	es, please check the box	and list	name.
	 □ Practitioner □ Advanced Practitione □ Physician's Assistant □ Physical Therapist □ Occupational Therapi □ Registered Nurse □ Respiratory Therapist 	st				

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

Within the last five (5) years:

This page must be submitted for all types of ownership.

1)	Has the corporation, any owner, 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 Æ
3)	Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry?		□ No ⁄□

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?

Yes 🗆 No 🗷

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?

Yes □ No □

If the answer to questions 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG provider or wholesaler 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.

W Londonatt	
Original Signature of Person Authorized to Submit Application	on, no copies or stamps
Ocilin Carmenate Livas	3/27/19
Print Name of Authorized Person	Date /

Board Use Only	Received:	Amount: 550,60

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.
Owner's Name: Daily Carmonate Rivas
Business Name: all fine Health care
Current Business Address: 4660 S Eastern Ave Ste# 100
City: State: Zip:
Telephone: 702 -480 -5617 Fax:

SOLE OWNER

Include with the application for a sole owner

<u>Complete personal history record</u> Must be original signature(s), no copies or stamps. Download the form from the website. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

SECRETARY OF STATE



NEVADA STATE BUSINESS LICENSE

ALL TIME HEALTH CARE LLC

Nevada Business Identification # NV20191240010

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 27, 2019

Barbara K. Cegavske Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law <u>cannot</u> be waived.

SECRETARY OF STATE



LIMITED LIABILITY COMPANY CHARTER

I, Barbara K. Cegavske, the Nevada Secretary of State, do hereby certify that ALL TIME HEALTH CARE LLC did on March 27, 2019, file in this office the Articles of Organization for a Limited Liability Company, that said Articles of Organization is now on file and of record in the office of the Nevada Secretary of State, and further, that said Articles contain all the provisions required by the laws governing Limited Liability Companies in the State of Nevada.



Certified By: Electronic Filing Certificate Number: C20190327-1751 IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 27, 2019.

Barbara K. Cegavske
Secretary of State

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Each MDEG shall employ an administrator at all times. The administrator must be:

- 1. A natural person.
- 2. Have a high school diploma or its equivalent.
- 3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
- 4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
- 5. Be approved by the board.
- 6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Durable Medical Equipment
Nature of MDEG All time Health oure 4660 S. Eastern ave ste 100 W NV 89/19 Name and Address of Business for Which MDEG Administrator Is Requested
Name and Address of Business for Which MDEG Administrator is Requested
If applicable, Name Under Which It Is Now Operated

1. PERSONAL	INFORMATION:				
_ Gutierre	ez A	ngelica			
Last Name		First Name		Middle Na	me
	NA				
Alias(es, Nicknar	nes, Maiden Name, Othe	r Name Changes,	Legal or Othe	erwise)	
Sp.	ring Rain Rd ce Address-Street or RFI	la:	s Vegas	NV	89147
Present Residen	ce Address-Street or RFI)	City	Sta	te/Zip
<u> 4660 S. B.</u> Present Business	Suite 100 Eastern Ave. Datest	hig Cas Ve	egas	NV Sta	89119 te/Zip
AdminiStr Present Position	mater Dates with the MDEG	4/1/19 -	· Present		——————————————————————————————————————
Phone:	- 1	Fax:	· · · · · · · · · · · · · · · · · · ·		
Email address: _	All time health	cave 19 @	gmail	com	
Date of Birth	Las Ve	GaS , ()SA , / Birth (City, County	V, State)		
22			- 1	F	
Age	Social S	ecurity Number		Sex	
Brown Color of Eyes	Rrown Color of Hair	120 Weight	-	50 Height	<u>.</u>
Scars, tattoos or o	distinguishing marks and/	or characteristics			
Are you a citizen	of the United States? Ye	es No 🗆		*	in .
If alien, registratio	n No	· · · · · · · · · · · · · · · · · · ·			
	ificate No				
-					

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

1		89104
<u>Jan 2017-20</u> Month and Year	19 Touro Health Center 874 Americ Name/ Address of Employer/Business	no of Employed Hours
Front officer	2 reception of Duties	Tina Galendo Name of Supervisor
September 2015— Mohth and Year	12017 3115 5. Bastern Ave. CUNV S9169 Name/ Address of Employer/Business	No of Employed Hours
Front office Title	reception of Duties	Patricia Webb. Name of Supervisor
March 2013 - Sep-20 Month and Year	Arck Care Los Vegas Name/ Address of Employer/Business	No of Employed Hours
Front office.	reception ist & Billing Description of Duties	Mario Tarquilino Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

or a physical condition that would impair my a license, including alcohol or substance abuse	ed or treated in the last five years for a mental illness billity to perform any of the essential functions of my
1. I have □ I have not been charged	l, arrested or convicted of a felony or misdemeanor.
	ect of an administrative action whether completed or
 I have □ I have not□ had a license disciplined, including any action agains 	suspended, revoked, surrendered or otherwise at a professional license that was not made public.
If you checked "I have" to questions 1, 2 and/o provide a written explanation and/or documen	or 3, please include the following information <u>and</u> ts.
a) Board Administrative Action:b)	State:
5)	Date:
	Case Number:
c) Criminal Action:	State:
	Date:
	Case Number:
	County:
	Court:
4. Will you be actively involved in and aw operation of the MDEG?	vare of the daily Yes ☑ No □
5 .Will you be employed fulltime with the	MDEG? Yes ☑ No □
6 .Will you be present at the site of the M during its normal operating hours?	IDEG Yes □ No □
If you answer No to questions 4, 5 or 6 please	provide a written letter of explanation.
	Date c 3/11/20/

Page 4 – MDEG Administrator

read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 3 27 19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for All Hiwe -	Health care	4660 S.	ature offlice	nse ave st	2 60 W NV	29119	•••••
	Name a	nd Address of Estab	lishment for	Which License Is	Requested		********
	•	If applicable, Name	Under Whic	h It Is Now Opera	ted	***********	**********
1. PERSONAL IN	IFORMATION:						
Last Name	ate Pivas	First N	ilin		Middle Name	·	
Alias(es, Nicknames, Ma	aiden Name, Other Nam	~					
<u> </u>	4	HOSO	Rioli.	c las le	90s, NV	89121	-1
Present Residence Addr	ess-Street or RFD		City		State/	Zip	
Present Business Address	Flanungo Pa	Dates	Las	s legal) NV	8912	<u>/</u>
QW	_		City	S	State/2	Zip	,
Occupation	1001	Dates			Phone:		
					Residence :	_	
* "	LOCITI	mas, Cu	laa		Business		
Date of Birth/	Usa 3 (1	Place of Birth (City	y, County, S	State)			
33	V 0.50		1007	•		T	1 -
Age	Social S	ecurity Number	-			FRM:	ale_
Black	Brown			172		E 3	
Color of Eyes	Color of Hair	Complexion		Weight	Build	Height	
Scars, tattoos or dis	tinguishing marks a	ind/or characteri	stics	n/A			
Are you a citizen of t	the United States?	Yes ☑ No □	If alien,	registration No	· #/17/	1 2006	N/A
If naturalized, certific	cate No			Date	11/12/2	001-	<i>7</i> ·····
					(4/1/2	000	********
Place Las VI	gus inlu	Jaa		(If naturalized	d, document mus	st be verified	.)
2. MARITAL INFO	RMATION:						
Single Marrie	d 🗹 Separated	☐ Divorce	d 🗆 '	Widowed 🗆	Engaged □		
				^	Applicant's initial	NO	P
				,	Abucant a unitidi	<i>V</i> .\	Page 1

M	ARI:	TAI	INFO)RMA	MOIT	-Continu	IPC
1 4 17	VI VI	1/_	1141	/ / 		-Commin	150

A.	Current Mar	riage $2/20$	2005	Las Ve	eas NV US	A
	Spouse's full	name (Maiden) OHQ	¹ 2005 n Deivys Gutiem	City, C S.S.	No	
	Date of Birth		J Place of B	irth Carden	as Matanzas	Cuba
			Osoulio Cir			
	Telephone:	Residence	Br	usiness		*****
	Spouse's em	ployer Self Em	iploy od	ccupation Driv	er	- I
	Address of er	nployer Street	ploy of Amazon De	clivery La	s llegas NV	•
B. Pr	evious Marria	ges: If ever legally se	parated, divorced, or an	nulled, indicate bel	ow:	
Name (of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State	
	<u> </u>	A				
	List of names	<u>, current address and t</u> Street	telephone numbers of p	revious spouses:	Zip Telephone	
		0.1001	Oity	Otate	Zip relephone	
3. FA A.		Dependents:				
	List all c Name	hildren, including step- Birth Date	children and adopted ch Birth Place		following information:	
Viliet	4 Gutierr	ez ,	USA	Ros	palio Cia LV	NV
Keily	in Gutier	rez 1	USA		OSORIOCX W	<i>n</i> //
thad	lica Gut	ierrez '	USA		ring Pain Rd	LVNV
В.		rt Information: e mark the appropriate	e response:		0	
	☑ la	m not subject to a cou	rt order for the support of	of child.		
	□ la pla	m subject to a court o	der for the support of or trict attorney or other pu	ne or more children	and am in compliance and the order for the repart	with a ayment
	the	e order or a plan appro	rder for the support of or ved by the district attorn ount owed pursuant to the	ey or other public a	agency enforcing the or	e with der for Page 2

FAMILY	/ INFORMATION-Continued District attorney or public agency responsible for enforcing the child support order:	
	Name	
	Address	
	Contact person	***************************************
C.	Parents: List names, residence addresses, dates of birth and most recent occupations of parents	
parents-		, step-parents,
	in-law or legal guardian. If retired or deceased, list last address and occupation. Name (Maiden) Birth Date Address	Occupation
Father	1,00,000	Occupation
NO	rbeito Carmenato Sauchez Deceas	sod.
Mother Market	earita Rivas Acuna / Pal	org Alle Lv. n
Mother-in-	que Ramire Z Pelegrin Palora Au	e WNV 891
	Brothers and Sisters: List names, residence addresses, dates of birth and most recent occupations of brothers their respective spouses. Name (Maiden) Birth Date Address Lev Cormenate Rives Lev Cormenate Rives	Occupation
		Kacker.
	oulin torres guerra Same Address	memploy.
Spouse		
Spouse		
Spouse		
4. EDU	JCATION:	
Grammar	Name of School Location Dates Attended	Graduate
School	El Dorado High school los lugal, NV 1999/2007	Yes No V
High <u>School</u>	VALLEY HIRLISCHOOL LOS LEGAS IN	Yes No I
College University	Las wegls (ollege las Wgows. 2003/2005	Yes ☑ No □
Other	V3111	
	Braillia.	Yes No D
Type of c	degree obtained, if any 1500Kkpmg	
College o	or university where obtained Las Utgas College.	
	9	

Applicant's initial DCR.

5 MILITARY INFORMATION:

A.	Have you ever served in any arm	rmed forces? Yes L No L				
	Branch	Date of entry-active service				
	Date of separation	Type of discharge				
	Rating at separation	Serial number				
	While in the military service were	e you ever arrested for an offense which resulted in summary ac Yes □ No □ If yes, furnish details on page 10. (List	tion, a trial or			
B.	Have you registered for the draft					
	County	State Date registered				
6. AF		TIONS AND ARBITRATIONS: (Include those arrests in which	h you were			
A.	violation for any reason whatsoev	etained, charged, indicted or summoned to answer for any criminater, regardless of the disposition of the event? (Except minor transpace provided below. List all cases without exception.	nal offense or affic citations.)			
Date of /	Arrest Age Charge	Location-City and State Deposition/Date Arrestin	g Agency			
		And and the state of the state				
B.	Has a criminal indictment, inform arrested or in which you were na page 10.	nation or complaint ever been returned against you, but for which amed as an unindicted co-party? Yes ☐ No ☑ If yes. furnish	n you were no details on			
C.		or deposed by a city, state, federal or law enforcement agency,	commission			
D.		ed to appear or testify before a federal, state or county grand jury	, board or			
E.	Have you ever been subpoenaed	ed to testify for any civil, criminal or administrative proceeding or	hearing?			
F.	Yes No Market No Market No. 1975 No. 19	ninal record expunged or sealed by a court order? Yes No				
G.	Have you ever received a pardor	city, county and state on or deferred prosecution for any criminal offense? Yes □ No				
H.	If yes when? Has any member of your family of the above	city, county and state or of your spouse's family ever been convicted of a felony? Yes ve questions (B through H) is yes, furnish details on page 10.	□ No 🗹			
Name	Rela	ationship Charge Location	Date _			
H. Name	Has any membe If you answer to	any of the abov	any of the above questions (B through H) is yes, furnish details on page 10.			
		Applicant's initial	Page			

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

		ils below. Lis	st all cases without ex	ception, including b	pankruptcies:	
aintiff/Defend aimant/Respo		Date Filed	Court and Case Number	City, County an	nd State	Disposition/Date
4330	Cialed Willi	il as all owne	business venture, so r, officer, director or p ete the following:	le proprietorship or artner) been a part	closely held co	orporation (while you varbitration or bankrup
Name	of Entity		Type of Entity		Approximate l Lawsuit/Arbitr	Date(s) of ation/Bankruptcy
. RESIDE		ave had for th	e last 25 years:			
t all reside	nces you ha	Street	e last 25 years: and Number	City	Stat	e or County
t all reside		Street	and Number ROSALIO C	ir Los Ve	State	1 11 0
t all reside onth and Year From-To) 2013- 2012/12	Presen /2013-	Street ?	Avacatuba	ir Loss Ve	igos, Neu	1 4
t all reside th and Year From-To) 2013- 2012/12 4-201	Presen /2013-	Street	Aracatuba Olève St H	AVU LAS U	egas, Neu Legas, Ne Llegas	uada USA wada USA W USH
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t all reside th and Year From-To) 2013- 2012/12 2012/12 9-201 09-20	7,48em /2013- 3 11	7 2900 500	Aracatuba Olive St H S. Marylan I Golden Ar	AM Las We pt 11 fas de Prwy row Dr L	egas, Neu Legas, Ne Legas Las Cus	uada USA wada USA W USA Bas 89189

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2015	press Tax Services 2840 E. Flamino Ro	1 Owner.
Title	Description of Duties	Name of Supervisor
Owner .	tax preparer -	SelF.
Month and Year to 01/2016	9. Name/Mailing Address of Employer/Business /785 F. Sahor	OReason for Leaving
CH / 2005 7017	At your Services Home Cowl . Aur Description of Duties	No more cleant
Kersonal coll	Visit client help w/doily Bosic.	ternando.
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
14. FI-40/102/10	1/Pm Home Colu 820 Rancho LN LV M Description of Duties	JV 39106 Batter Salar
	Description of Duties	Name of Supervisor
ersonal cou	Visit clients help updoing come Bosic.	
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
06/2005/12/2013	1 11 11 11 11 11 11 11 11 11 11 11 11 1	
Title	Description of Duties	Name of Supervisor
Henden't	hostock mini Barin Hotel Rooms.	Se Bastlan.
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/18-Present	Allstate Ans. 3265 f. tropicoma Au	Name of Supervisor
Title	Description of Duties	
Sales s	sale ins. Policys.	Yolanda Sitto.
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial

Page 6

9. CHARACTER REFERENCES:

	<u>emplover or e</u>	cter reference w	ho have know yo	ou five years o	r more. Do no	t include relatives, ¡	oresent
Care	Where Employed	Street	City State	Zip Zip	Telephone	Years	Known
Name	Zeandro R	1	IT W IVV	39169	4		wt.
	er wynn Ho	1	0 -	Lugas B	-	170-700U	10+
	oura Senc	_	2 Del 1614			0.	ちます
Employe	E 1		3265 E. T	to pi cay		-J LVW	
	polondon C	_		lagina D	Y LVIVV	7 39139 6	Years
Employe	1 0 :	4 -	3265 E. T	DPRAIN	halle E	I W WV	702706-7
Name\	USIMI BEL	of thome	t. +M	begins a	EVE LVIN	N 8-8104	10 years
Employe	Mazon	Business	\ - P		A 4	<u> </u>	
Name	YUS PH	Jain S	Se0	Fuper	1	l	
Employe		PloyBusiness		1 Critic	loyed	6 Years	
10,	person's depor	ny safe deposit sitory? Yes □ l ete the followin	NO M	n depository, a	access to any o	lepository or do you	ı use any other
Box Nun	ber or Type of Dep						
DOX 11GII	ibei of Type of Dep	ository	Location	City and State	Aui	thorized Users	
11.	Liquor Doctor Accountant Yes 🖾 No 🗆	Lawyer Contractor Pilot Pe, where and ye	Race horse/rac Real estate bro Sports promote	e dog owner ker or salesm	Se an Ba	state, including but curities dealer rber/Cosmetologist ainer or manager	Insurance
8 IV	rsuranc	e la	s Ulgas	NV	1/24/20	117	***********
	***************************************			***************************************			
√12.	Interest in a lice If yes, state typ involved, the na venture or indu	ensed business le, when and wh ames and addre	or industry OUTS ere and give nan ss of all partners	SIDE the State nes and location and the ageno	of Nevada? Yons of the busing responsible	y license puheld a les ID No Ponesses in which you for licensing said b	u were usiness,
	X KNOWN X	n toon i	02 100 LOV -	7016	Droc	ont	
10	112 1001		- Turkey	201	7-11-69		
284	O E. Plav	ration in	1 Suitc	ias lle	gas, N	89121	

13.	Have you ever appeared before any licensing agency any reason whatsoever? Yes □ No ☑	or similar authority in or outside the State of Nevada for
14.	Have you ever been denied a personal license, permiror professional activity? Yes □ No ☑	t, certificate or registration for a privileged, occupational
If yes	to the above, state where, when and for what reason:	
15.	Have you ever been refused a business or industry lice participant in any group which has been denied a business suitability?	
16.	Have you or any person with whom you have been a padministrative action or proceeding relating to the pha	
17.		participant in any group ever been found guilty, plead nse, federal or state, related to prescription drugs and/or
18.		participant in any group ever surrendered a license, maceutical industry voluntarily or otherwise (other than Yes □ No ☑
19.	Do you have any relatives within the fourth degree of pharmaceutical or drug related industry?	consanguinity associated with or employed in the Yes □ No ☑
*********		A7

		Date of photograph 3/11/19
		Applicant's initial Page

the

STATE OF NUADA
SS.
COUNTY OF Clark
I, Dailin Cameral Rivas, being duly sworn, depose and say I have read the
foregoing application and know the contents thereof; that the statements contained herein are true and correct and
contain a full and true account of the information requested; that I executed this statement with the knowledge that
misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of
a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised
Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license,
registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing
of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and
further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the
Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as
promulgated thereunder and agree, if licensed, to abide thereby,
I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their
agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors
can, shall or may have against the State of Nevada, the licensing agency and their agents, as a result of my applying
for a manufacturer license in the State of Nevada.
State of Nevada & XXI BILLIAN
/ Original Signature of Applicant
County of Clark
Subscribed and Sworn to before me this 25th day of march 2019
Dailin Chimenate - Rivas
Notary Public JOHN ACEVES
Notary Public - State of Nevada
(Seal) County of Clark APPT. NO. 08-7219-1
My App. Expires Sep. 1, 2020

Applicant's initial Page 9

ADDITIONAL INFORMATION

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······································

Applicant's initial

Page 10

12B

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$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

and or the state of Novada.
New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change (Please provide current license number if making changes: MP or MW)
□ Publicly Traded Corporation – Pages 1,2,3,4 □ Partnership - Pages 1,2,3,6 □ Sole Owner – Pages 1,2,3,7 □ Please check box for type of ownership and complete correct part of the application.
GENERAL INFORMATION to be completed by all types of ownership
MDEG Name: Otto Bock OcthopeDic Services LLC
Physical Address: 2780 S. Jones Blub Ste 140 LAS Vogas, NV 89116-56 (This must be a business address, we can not issue a license to a home address)
Mailing Address: 11501 Alterra Pkwy Ste 600 - AHN Jessica SALATINO
City: <u>Aust-IN</u> State: <u>TEXPS</u> Zip Code: <u>78758-3597</u>
Telephone: 5/2-806-2628 Fax: 866-642-230 2
E-mail: US_OS_NPRC_DepARTMent & Website: www.oflobockus.com
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 9:00 to 3:30 Tue: 9:00 to 3:30 Wed: 9:00 to 3:30 Thu: 9:00 to 3:30
Fri: 9:00 to 3:30 Sat: (1000) Sun: (1000) Holidays: (1000) to
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Sharon Clark
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
☐ Medical Gases** ☐ Assistive Equipment
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☐ Diabetic Supplies ☐ Orthotics and Prosethics ☐ Other:
**If providing these types of services you are required to have in place a mechanism to ensure
continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Tim Alouzi.

Page 1

This page must be submitted for all types of ownership.

AZ- 633 Co - 633 FL- 6337 RL- 6337 MD- 633	7600034	0H-6337600032 0K-6337600036 PR-6337600031 TX-6337600001	hbers registered to the business or it MED ICAID AZ-445525 WI-100043510 OK-20049510D AZ-8468690 PA-1024093690 AD-0332691		r: - -
	7600030	UT-6337600035	TX-211914103 UT-3009687 NC-1104206499		
1)	Do any sharehold any type of busin or another politic	less or facility which a	ownership or have management in are licensed by the State of Nevada	Yes □	No 🔤
2)	Are you or have y business or healt dispensed or dist	n care entity in which	een associated with any person, MDEG products were sold,	Yes 🗖	
3)	Are any of the ow	ners health profession	nals? If yes, please check the box a	and list	name.
	☐ Practitioner ☐ Advanced Pra ☐ Physician's As ☐ Physical Thera ☐ Occupational ☐ Registered No ☐ Respiratory Th	apist Therapist urse	Name: M/P		

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

This page must be submitted for all types of ownership.

Within	the	last	five	(5)	years:
--------	-----	------	------	-----	--------

1)	Has the corporation, any owner, shareho any interest, ever been charged, or conversion.	ricted of a felony or gro	oss	· ·
	misdemeanor (including by way of a guil	ty plea or no contest p	lea)? Yes □	No D
2)	Has the corporation, any owner(s), share any interest, ever been denied a license	eholder(s) or partner(s)) with f	
	registration?	Yes [No X	
3)	Has the corporation, any owner(s), share interest, ever been the subject of an admrelating to the pharmaceutical industry?	eholder(s) or partner(s) ninistrative action or pro	oceeding	No 151
4)	Has the corporation, any owner(s), share interest, ever been found guilty, pled gu contendere to any offense federal or stat substances?	ilty or entered a plea or	f nolo	No [X]
E) =	Hos the comment			110 4
5)	Has the corporation, any owner(s), share interest, ever surrendered a license, per voluntarily or otherwise (other than upon	mit or certificate of reg	istration	No <table-cell></table-cell>
attach	nswer to questions 1 through 5 is "yes", ed. Copies of any documents that identif er disposition may be required.	a signed statement of y the circumstance or o	explanation must be contain an order, ag	e reement,
lunder	y certify that the answers given in this applica stand that any infraction of the laws of the St zed MDEG provider or wholesaler may be gr	ate of Nevada regulating	the operation of an	d correct.
penalty hereby any inv	read all questions, answers and statements a of perjury, that the information furnished on authorize the Nevada State Board of Pharm estigation(s) of the business, professional, so on, as it may deem necessary, proper or des	this application are true, acy, its agents, servants ocial and moral backgrou	accurate and correct	. 1
Origina	al Signature of Person Authorized to Subr	nit Application, no copi	es or stamps	
0	anilo Sarria	4//	19/10	
	ame of Authorized Person	Date		
Board	Jse Only Received:	Amount: 2	500.00	

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: MINNESOTA
Parent Company if any: Otto Bock HearthCARE NORTH America XNC.
Corporation Name: Otto Bock Hearthcare North America INC
Mailing Address: 11501 Alterra P Kwy Suite 600
City: AUSTIN State: TEXAS Zip: 78758-3597
Telephone: 800-328-4058 Fax: 866-642-2902
Contact Person:
For any corporation non publicly traded, disclose the following:
1) List top 4 persons to whom the shares were issued by the corporation?
a) See Attached Name Address
Name Address
b)Name Address
Name Address
C)Name Address
/ Marcos
d) Name Address
NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the "New Applications" tab. The forms are available under the documents for all types of businesses.
2) Provide the number of shares issued by the corporation. <u>Steatlached</u>
What was the price paid per share?
4) What date did the corporation actually receive the cash assets?
Provide a copy of the corporation's stock register evidencing the above information

NON PUBLICLY TRADED CORPORATION

Include with the application for a non publicly traded corporation

<u>Complete personal history record</u> for each stockholder. Must be original signature(s), no copies or stamps. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

<u>Certificate of Corporate status</u> (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors.

ottobock.

March 27, 2019

Nevada State Board of Pharmacy 431 W Plumb Lane Reno, NV 89505

Dear Nevada State Board of Pharmacy,

I am submitting our Medical Device Equipment and Gases application for our **Prosthetic/Orthopedic/DME Division**, <u>Otto Bock Orthopedic Services LLC</u> (Tax ID#: 32-0288792). In regards to Page 5a, Question 1, we are wholly owned by Otto Bock Healthcare NA, Inc. (Tax ID#: 41-0824465). We are not publicly traded, nor do we have publicly issued shares. I am attaching out current W9 to further support the chain of ownership of our organization. If you have any additional questions, please do not hesitate to contact me.

Kindest Regards,

Jessica Salatino

Billing Operations Project Manager

11501 Alterra Parkway

Suite 600

Austin, Texas 78758-3597

Phone: 512.806.2628

Jessica.Salatino@ottobock.com

Ottobock Orthopedic Services, LLC 11501 Alterra Parkway Suite 600 Austin, TX 78758 T 800 711 2205 www.ottobockus.com

Office of the Minnesota Secretary of State

Minnesota Limited Liability Company/Annual Renewal

Minnesota Statutes, Section 5.34



Annual Renewal Year:

2018

Annual Renewal Filing Date:

12/10/2018

Corporation Name:

Otto Bock Orthopedic Services LLC

Original Filing Number:

3397306-2

Home Jurisdiction:

Minnesota

Filing Party Information:

Party Type:

Name:

Address:

Manager

Andreas Schultz

11501 Alterra Parkway Suite 600 Austin TX 7875811501 Alterra Parkway Suite 600 Austin TX 78758

Principal Executive Office

Address

Registered Agent

Corporation Service

Company

Registered Office Address

2345 Rice Street Suite 203 Roseville MN 55113



Work Item 1052932400021 Original File Number 3397306-2

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
FILED
12/10/2018 11:59 PM

Steve Simon Secretary of State

Oteve Vimon

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 3 / 2 9 / 1 9

Each MDEG shall employ an administrator at all times. The administrator must be:

- 1. A natural person.
- 2. Have a high school diploma or its equivalent.
- 3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
- 4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
- 5. Be approved by the board.
- 6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

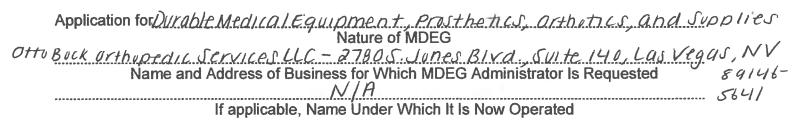
A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.



1. PERSONAL INFORMATION:

Hamilton		Irma Glori	Irma Gloria				
Last Name		First Nar	First Name		Middle Name		
Irma Gloria Peralt	a, Gloria Hamiltor	1					
Alias(es, Nicknar	nes, Maiden Na	me, Other Name	Cha	anges, Legal or O	therwise)		
\utumn Ha	nze			Las Vegas	1	١V	89117
Present Residen	ce Address-Stre	et or RFD		City			te/Zip
2780 S Jonas I	Blvd, Suite 140	Dates		Las Vegas	N	1V	89146
Present Business	s Address			City			te/Zip
Service Center A Present Position		Dates					
Phone: 800-736-	8276	Fa	x: _	866-632-2303			
Email address:	JS_OS_NPRC_	Department@otte	obo	ck.com			
Date of Birth	_	San Diego,					
61		* II .			F		
Age	· 	Social Security N	Vun	nber	Sex	,	-
Brown	Brown	14	5 lb	os	5'4"		
Color of Eyes	Color of Hair	We	eigh	t	Height		
Scars, tattoos or	distinguishing m	arks and/or chara	acte	eristics None			
Are you a citizen	of the United St	ates? Yes ⊠ No			•		· · · · · · · · · · · · · · · · · · ·
If alien, registration	on No						
If naturalized, cer							
Place				(If naturalized, de			

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

	Prime Health Care dba West Anaheim Med Ctr		
03/2016-03/2019	3033 W Orange Ave, Anaheim, CA 92804	6200 hours	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours	
Insurance Verifier	Verification of patient insurances	Billy Cevallos	
Title	Description of Duties	Name of Supervisor	
	Discover Wellness Health Association		
01/2009-03/2016	438 E Katella Ave, Suite B Orange, CA 92867	14,000 hours	
Month and Year	onth and Year Name/ Address of Employer/Business No of Emplo		
Medical Billing Mgr	Medical Billing and Claims	Kristie Niang	
Title	Description of Duties	Name of Supervisor	
		et e er e	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours	
Title	Description of Duties	Name of Supervisor	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours	
Title	Description of Duties	Name of Supervisor	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours	
Title	Description of Duties	Name of Supervisor	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours	
Title	Description of Duties	Name of Supervisor	

or a physical condition that would impair my a license, including alcohol or substance abuse	ed or treated in the last five years for a mental illness ability to perform any of the essential functions of my e,
1. I have ☐ I have not☑ been charged	d, arrested or convicted of a felony or misdemeanor.
 I have ☐ I have not ☒ been the subpending. 	ject of an administrative action whether completed o
 I have □ I have not □ had a license disciplined, including any action against 	suspended, revoked, surrendered or otherwise st a professional license that was not made public.
If you checked "I have" to questions 1, 2 and/provide a written explanation and/or documer	or 3, please include the following information <u>and</u> nts.
a) Board Administrative Action:b)	State:
b)	Date:
	Case Number:
c) Criminal Action:	State:
	Date:
	Case Number:
	County:
	Court:
4. Will you be actively involved in and avoperation of the MDEG?	
5 .Will you be employed fulltime with the	
6 .Will you be present at the site of the Muring its normal operating hours?	
f you answer No to questions 4, 5 or 6 please	provide a written letter of explanation.
	AT
	Date of photograph 3/28/19

I, Irma Gloria Hamilton , being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Original Signature of Applican

Page 1

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE for a Pharmacy or Wholesaler located in Nevada

V Date 3/27/2019

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

		If applicable, Name Unde	er Which It Is Now O	perated	
1. PERSONAL I	NFORMATION:				
Last Name		Danilo			
NAN		— First Name	_	Middle Name	
Alias(es, Nicknames, N	laiden Name, Other Nam	e Changes, Legal or Oth	erwise)		
Stratu	IS DYIVE Iress-Street or RFD Park way ess	Drippin	14 Sonous	TX 786	DΛ
Present Residence Add	Iress-Street or RFD	C	id Springs	TX 7862 State/Z	Zip
Svite 100	Parkway	Dates	AUS	10, TX 78 State/7	758
			ity	State/Z	Zip
VP of Opera	ations e Pharmacy or Wholesa	Dates			
Present Position with th	e Pharmacy or Wholesa	er		Phone: Residence (
1 9					0-281-223
				Business 70	U 201-200
Date of Birth		Place of Birth (City, Co	ounty, State)		
50	Ć	% =			M
Age	Social	Security Number			Sex
BROWN	BROWN	WHITE	215	ATHLETIC	62"
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Scars, tattoos or di	stinguishing marks	and/or characteristic	s NA		
Are you a citizen of		Yes ☑ No □ If		n No	
	icate No		Date /	1/15/88	
If naturalized, certif	***************************************				at be verified.)

the order or a plan approved by the district attorney or other public agency enforcing the order for

Applicant's initial

the repayment of the amount owed pursuant to the order.

FAMIL	Y INFORMATION-Continued District attorney or public agency responsible for enforcing the child support order:	
	Name WA	
	Address	
	Contact person	
C.	Parents:	
parents	List names, residence addresses, dates of birth and most recent occupations of parents	, step-parents,
====	in-law or legal guardian. If retired or deceased, list last address and occupation. Name (Maiden) Birth Date Address	Occupation
Father		
	UNKNOWN	
Mother	ADOPTED MOTHER	, , , , , , , , , , , , , , , , , , , ,
Father-in		
	GEDIGE KNOTTIL DECEASED	
Mother-in	n-Law	
	BARBARA CORY - ? : S. THAST #316 PADENIX AT	RETIREN
D.	Brothers and Sisters:	9
Ο.	List names, residence addresses, dates of birth and most recent occupations of brothers	and sisters and of
	their respective spouses. Name (Maiden) Birth Date Address	Occupation
	NA	S G G G G G G G G G G G G G G G G G G G
Spouse		
Spouse		
Spouse		
Spouse		
Spouse		<u> </u>
Spouse		
	k.	***
4. ED	DUCATION:	
	Name of School Location Dates Attended	Graduate
Grammar School	EDISON ELEMENTARY I'HOENIX, AZ 1980-1982	Yes No 🗆
High School 4	CAMERBACK HIGH SCHOOL PHOENIX, AZ 1982-1986	Yes 🔽 No 🗆
College	ARIZONA STATE UNIVERSITY TEMPE, AZ 1998-2004	Yes ☑ No □
	INNERSIY OF PADENIX PHOENIX, AZ 2004-2009	
	degree obtained, if any MASTERS OF BUSINESS ADMINISTICATION	Yes Mo L
	e or university where obtained UNIVERSITY OF PHOENIX	
Jonege	of differently whole obtained virious if I I I I I I I I I I I I I I I I I I	<u> </u>
	Applicant's initial	

Applicant's initial

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I.	part to a lawsu Yes □ No ᡚ	it as either a p (Other than o	plaintiff or defendant or a divorces)	or owner, director or officent arbitration as either a classition, including bankrupte	
	/Defendant or nt/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
J.	associated with	as an owne الزا	business venture, sole per, officer, director or partete the following:	proprietorship or closely hand	eld corporation (while you we suit, arbitration or bankruptcy
	Name of Entity		Type of Entity		imate Date(s) of t/Arbitration/Bankruptcy
	-				
7. R	ESIDENCES:				
List all	residences you l	nave had for th	ne last 25 years:		
Month a (From	nd Year n-To)	Street	and Number	City	State or County
06/2	2015 - PRESE	N7	STRATUS DRIVE	DRIPPING SPRINGS	
27/2	014-06/201	5 4125	SUGMILLONF DILIVE	AUSTIN TX	TX
04/2	012-07/201	4 5223	S. BIG HORN PZ	CHANDLER	AZ
			4 S. 27TA AVE,	PHOENIX	AZ
05/2	2003-05ko	05 287	W. SILVER FOX	PHOENIX	AZ
1	199-05/200		W. MOUNTAIN SAG	= PADENIX	AZ
0/19	997 - 10/19	99 1100	E. OSBORN RD	PHOENIX	Æ
			W. VERNON AVE	PHOENIX	AZ
/	183 -10/199		. CAMBRIDGE AVE	PHOENIX	AZ

Applicant's initial

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

5/2008	OTTOBOCK 11501 ACTERRA PARKWAY, SUITE 600.	AUSTIN, TX 78758 22,
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
IP, OPERATIONS	EXECUTIVE SIRECTOR OF ORTHOIEDIC SERVICES	S ANDREAS SCHULTZ
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

	List five character reference employer or employees.	ce who have	know you five	years or more	. Do not include	e relatives, pr	esent
	Where Employed Street	City	State Zip	Te	lephone	V	n
Name	JON SCHWARTZ Home	? E. M	ARLETTE AVE	PITOENIX, 1	12 850/6	40	
Employe	STATE OF ARTZONA Busines	s AZ SUR	EME COURT	JULGE			7
	ANN ADAMS Home			CAMBLER	AZ 85286"	25	~
Employe	REALTOR BROKER Busines	S ANN A	Asms & As	SOCIATES			
Name C	SEORGE BAKTER Home	?NE	AKE PLEASA	NTRD JEDRI	A, AZ 05700	37	
Employe	U.S. POSTAL SERVIE Busines		WERVISOR		_		
Name 7	Home.	SENOR	THRIDGE ST.	MESA, AZ 85	, 273=	11	
Employe	VALLEY SLEET CONTIN	S OPERAT	IONS MAN	HER	_	4	
Name /	NNE WALMSLEY Home	BLAI	RSVILLE 14W	Y MURPHY,	NE 28903	8	
Employe	ADVANCES ORTHO Busines	DIRECTOR	OF SALES	(ORTHOTICS)			
10.	Have you ever held a privil the following: Liquor Lawyer	Race h	orse/race dog	g owner	Securities	dealer	Insurance
	Doctor Contractor Accountant Pilot Yes □ No □ If yes, state type, where ar	Sports	state broker o promoter	r salesman	Barber/Co Trainer or	smetologist manager	Gaming Educator
11,	Have you ever applied for interest in a licensed busin If yes, state type, when and involved, the names and a venture or industry.	ess or indust d where and	ry OUTSIDE t give names ar	the State of Ne nd locations of	vada? Yes □ I the businesses	No 🗗	were
12.	Have you ever appeared b any reason whatsoever? Y NEVADA BOAR	efore any lice es No D	ensing agency		ority in or outsid		
13.	Have you ever been denied or professional activity? Ye	d a personal		t, certificate or	registration for	a privileged, o	occupational
f yes to	the above, state where, where where where where where where we have a second state of the control of the contro	ien and for w のドパH4か いた Fのぶへ	hat reason: MACY M R LOCATO	Note LICE	NSE IN ZO S VEGAS	VO W41	CH WAS

Applicant's initial.

	14.	participant in any group which has been denied a business or industry license or related finding of suitability? Yes		
	15.	Have you or any person with whom you have been a participant in any group been the subject of administrative action or proceeding relating to the pharmaceutical industry? Yes □		
	16.	Have you or any person with whom you have been a participant in any group ever been found gui guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription controlled substances? Yes	drug	s and/or
	17.	Have you or any person with whom you have been a participant in any group ever surrendered a l permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (upon voluntary close of a wholesaler Yes □	othe	r than
	18.	Do you have any relatives within the fourth degree of consanguinity associated with or employed in pharmaceutical or drug related industry? Yes □		
	•••••			
	19.	Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler?	No	
	20.	Will you be employed fulltime with the pharmacy or wholesaler?	No	
	21.	Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes \Box	No	
•••		Date of photograph $3/30/19$		•••••
		Applicant's initial	<u>>,</u>	Page 8

SS.

COUNTY OF IPAVIS

I, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a wholesaler license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or wholesaler in the State of Nevada.

Original Signature of Applicant

Subscribed and Sworn to before me this

200

day of

/ pn.!

2019

No Co

JOHN D. PRICE
Notary Public, State of Texas
Comm. Expires 04-11-2022
(State) ID 128226294

Applicant's initial

Applicant's	initial	 	 	 	
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9 Date 04/05/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for				
	Nature of Licens	se		
Name and Ad	dress of Establishment for V	Vhich License Is Re	equested	
lf app	licable, Name Under Which	It Is Now Operated		
1. PERSONAL INFORMATION:	ANDREA	S	LUDWIG	
Last Name	First Name		Middle Name	
Alias(es, Nicknames, Maiden Name, Other Name Cha				-
PLEASANT PA	NORAMA	VIEW F	usiin '	TX 78738
Present Residence Address-Street or RFD	City		State/Zip	
11501 ALTERRA PKWY Da	tes AUS	TIN	TX	78758
Present Business Address	City		State/Zip	
	tes			
Occupation			Phone:	
- •		13,1991		220 1102
Date of Birth Pla	ELLE, GE	ehany	Business 6.1.	27351172
Date of Birth Pla	ice of Birth (City, County, St	ate)		
50				MALE
Age Social Securi				Sex
BLUE BLOUDISKEY	FAIR	22006		6'1"
0.1	Complexion	Weight	Build	Height
Scars, tattoos or distinguishing marks and/o	or characteristics			
Are you a citizen of the United States? Ye	es □ No 🕻 If alien,	registration No		*
If naturalized, certificate No.		Date		*******************************
Place	<u></u>	(If naturalized,	document must	be verified.)
2. MARITAL INFORMATION:				
Single ☐ Married 【 Separated ☐] Divorced □ \	Widowed □	Engaged 🗆	0.0
		Ap	plicant's initial	HS

. Current Ma	arriage 12/ 2	2105				W. 115
Spouse's fu	ull name (Maiden)	CORIA	CONGHU	YEN City,	County and State S. No	
	th					
	ddress Street			quew Au		
	Residence					
Spouse's e	mployer		Occ	cupation #0	henakei	2
Address of	employer.			City	State Zip	
. Previous Marı	riages: If ever legal					
ame of Spouse	Date of Order or Decree		e of Place Marriage	Nature of Action	City County and S	State
Nan	ne Street		City	State	Zip Telep	hone
	nd Dependents: children, including see Birth Dat	e Birth	and adopted chi Place HOUSTON, WEICH, SU	Resi	e following inform dence Address	nation: THIVORAMA PR735
	port Information: ease mark the approp	oriate respons	se:	921		
ĸ	I am not subject to a	court order f	or the support o	f child.		
	I am subject to a cooplan approved by the of the amount owed	e district attor	ney or other pul			
	I am subject to a cou the order or a plan a the repayment of the	pproved by the	ne district attorn	ey or other public e order.		

FAMIL	LY INFORMATION-Continued	
	District attorney or public agency responsible for enforcing the child support order:	
	Name	
	Address	***********
	Contact person	
C.	Parents:	
parent	List names, residence addresses, dates of birth and most recent occupations of parents	, step-parents,
	in-law or legal guardian. If retired or deceased, list last address and occupation.	
	Name (Maiden) Birth Date Address	Occupation
	LUDWIG SCHULTZ 1 ,3 1 GOCKEWHOLZ/GERMAN	DECEMED
	DELGARO SCHULTZ 1 "Y" ILACHEN DOZFIGERT	ANY PETIPE
Father-i	n-Law o 3EEOHNUT#421	
	TLIP VINH CXUOC of HOUSTON TX 770 83	KEIIKEI
Mother-i	in-Law "0 & EECHNUT # 420	2 0
510	CH NGOC NGUYEN I HOUSTON, TX 77083	RETIRE
D.	Brothers and Sisters:	
D.	List names, residence addresses, dates of birth and most recent occupations of brothers	s and sisters and of
	their respective spouses.	
Aur	Name (Maiden) Birth Date Address	Occupation LAW
MILI	HAELA KRUSCHELISKI THE TELLE IGERTALY	CLERK
Spouse		
Spouse		
Spouse		·
Spouse		
4. E	DUCATION:	
	Name of School Location Dates Attended	Graduate
Gramma School		Yes 🗌 No 🔲
High School	BFBS I CFUE, GERRANY 1929-1990	Yes X No
	BFBSI CEUF, GERHANY 1989-1990 THOFFENBURG OFFENBURG 1991-1995	The second secon
		Yes X No □
Other		Yes 🔣 No 🗆
Гуре о	of degree obtained, if any EXECUTIVE 913A	
الم	e or university where obtained Uo+CHICAGO	
Sollege	e of university where obtained	***************************************
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Applicant's initial_____

Page 3

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Applicant's initial

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pa Ye	art to a lawsi es □ No 🔽	uit as either a Other than	member of a par plaintiff or defend divorces) ist all cases witho	dant or an	arbitration as eit	her a cla	aimant d	corporation or responde	ever be ent?
laintiff/Defer laimant/Res		Date Filed	Court and Case Number	е	City, County and	State		Dispositio	n/Date
ass	sociated wit	h it as an own	o, business ventu er, officer, directo lete the following	or or partr	roprietorship or c ler) been a party	losely he	eld corp suit, arl	poration (who	nile you v bankrup
Nar	me of Entity		Type of Entity	*			imate Dat	te(s) of on/Bankruptcy	/
7. RESID	DENCES:								
onth and Ye	dences you		the last 25 years:						
onth and Ye	dences you	Stree	et and Number		City ALST	n/	A	or County	P
onth and Ye	dences you ear	Stree	et and Number	PANORA	City HAVW AUSTI AUST IN	N ₄	State of TX	7873	8
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Applicant's initial Page 5

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Month and Year 01 01 2010	Name/Mailing Address of Employer/Business OTTOBOCHTC LP 11501 ALT EREAL Description of Duties	118-58
Title	Description of Duties	Name of Supervisor
CFD	FINANCIAL + SHAPEOSERUCES OVER	SIGHT BEROPUHL
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
olloll 1775	BACHTOBELSTENSIE 3, C# -8810 HORS	IEN BETTER OPPORTUNITY
P TIMME	Description of Duties	Name of Supervisor
R. FINANCE	granager Econopic Evaluation	CECILIA FALCO
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
61991-09/199	1 UNEHILOYED	
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
111971-0511	991 RPC, BRENT EWEG 205 29223 CEUE	
WOLKER	Description of Duties	Name of Supervisor
MOFFEE	LOGISTICS ACTIVITIES	NI A
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
0/1990-12/19	no unehployed	
Title	Description of Duties	Name of Supervisor
A-th-dy	Now Africa Address (F. 1)	
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
11 1787 - 01	MITTEL UN EP (FLOYED	Name of Occasion
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Descen for Leaving
081(986-071	1988 HOBEL UNGTKICLOSED	COMPLETED APPRENTIC
Title	Description of Duties	Name of Supervisor
ALFSMAN	APPLENTICESHIPTOSNESMA	N DIETER LOWAG
Manth and Vaca		
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

Applicant's initial....

	List five chara employer or e	cter reference	who have know	w you five yea	rs or more. [Do not include rel	atives, prese	ent
Name o	of Where Employed	Street	City Sta		Telep	hone	Years Knov	 vn
Name	SANDRA 3	ACAHome	W. Li	NDALN. G	ANOUBIC H	1285224		7 Fyzak
Employe	er SEPE	Business	HEALTH	CAPE				V
	EESHA had		, E. Noe	THEIDGE S	T. MESA,	A285213		D 84000.
Employe	e NAMEN SCEED	CAUTER	HERLTH	CARE				
Name /	aung walks	LEY Home	BLAIRS	VILLE HWY	1 MURRHY	NC28703		3 8 gas
Employe	er ADVANCO B	ETHO Business	HEALTH		N.			
Name [eaf krügi	FR Home			- 7WF	DENSUIL.		H204
Employe	-POW EUROP	Business	CHEMIC	AC				0
Name	els Fuhha	Home	SPRINGWI	ATER DR.	JUPITER	, FL 33 158	£	0950
Employe	WELLS PHARE	ACY Business	HEALTH	KARE	0	,FL33458		- 0
10.	person's depo	ny safe depositsitory? Yes □ ete the followir	No 🌠	such deposito	ry, access to	any depository o	r do you use	any other
3ox Nun	mber or Type of Dep	ository	Location	City and S	tate	Authorized Users		
11.	Liquor Doctor Accountant Yes No	Lawyer Contractor Pilot	Race horse Real estate Sports pror	e/race dog owr broker or sale	ner	n any state, includ Securities dea Barber/Cosme Trainer or mar	ler In	limited to surance saming ducator
12.	Interest in a lice of the lice	ensed business be, when and wh ames and addre	or industry O here and give	UTSIDE the S names and lo	tate of Nevac cations of the	idustry license or da? Yes □ No I businesses in w sible for licensin	ૣ hich vou we	ere
			Ge .					
					F	Applicant's initial	AS	•
								Page 7

Applicant's initial_____

Date of photograph

COUNTY OF TRAVIS

I, ANDREAS SCHUUTE, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and their agents, as a result of my applying for a manufacturer license in the State of Nevada.

pinal Signature of Applicant

Subscribed and Sworn to before me this day of

promulgated thereunder and agree, if licensed, to abide thereby.

JOHN D. PRICE Notary Public, State of Texas Comm. Expires 04-11-2022 Notary ID 128226294

(seal)

Applicant's initial

Applicant's initial Page 10

499

12C

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$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.

laws of the State of Nevada.
New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change (Please provide current license number if making changes: MP or MW)
☐ Publicly Traded Corporation ☐ Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6 ☐ Non Publicly Traded Corporation ☐ Pages 1,2,3,5a,5b ☐ Sole Owner ☐ Pages 1,2,3,7 Please check box for type of ownership and complete correct part of the application.
GENERAL INFORMATION to be completed by all types of ownership
MDEG Name: <u>Viovidence</u> Medical Sypty Physical Address: <u>1729</u> E Charles hon Blud H = In S Veges 86 (This must be a business address, we can not issue a license to a home address)
Physical Address: 1729 E Charleston Blud It Flas Vegas 80
(This must be a business address, we can not issue a license to a home address)
Mailing Address: 1127 E Charleshon Blod TIF
City: Las Vegas State: W Zip Code: 89154
Telephone: 702-982-0078 Fax: 72 485 6332
Mailing Address: 1729 E Charleshon Blud #F City: Las Vegas State: W zip Code: 89164 Telephone: 702-982-0078 Fax: 702 485 6332 E-mail: Dyzeb@yahov. Com Website: N/A
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 9 to 6 Tue: 9 to 6 Wed: 9 to 6 Thu: 9 to 6 Fri: 9 to 6 Sat: to Sun: to Holidays: to
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Modupe Ivorobegé
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
 ☐ Medical Gases** ☐ Respiratory Equipment** ☐ Life-sustaining equipment** ☐ Diabetic Supplies ☐ Assistive Equipment ☐ Parenteral and Enteral Equipment** ☐ Orthotics and Prosethics ☐ Other:
**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Telephone:

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List al	Medicare and Medicaid provider numb	ers registere	d to the business or it	ts owner:
15	58824607			
1154	58824607 4703905			
1)	Do any shareholders hold an interest of any type of business or facility which are or another political jurisdiction?	wnership or licensed b	have management in y the State of Nevada	Yes 🗆 No 🗗
2)	Are you or have you in the last year been business or health care entity in which dispensed or distributed?	en associate MDEG produ	d with any person, ıcts were sold,	Yes □ No □
3)	Are any of the owners health profession	nals? If yes,	please check the box	and list name.
	 □ Practitioner □ Advanced Practitioner of Nursing □ Physician S Assistant □ Physical Therapist □ Occupational Therapist □ Registered Nurse □ Respiratory Therapist 	Name: Name: Name: Name: Name: Name:		

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Withir	the last five (5) years:	
1)	Has the corporation, any owner	, shareholder(s)

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 ☑

or partner(s) with

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration?

Yes □ No □

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry?

Yes □ No ☑

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?

Yes □ No ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?

Yes □ No □

If the answer to questions 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized MDEG provider or wholesaler 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

Mobult IROROBÉTE

4/10/2019

Print Name of Authorized Person

Date

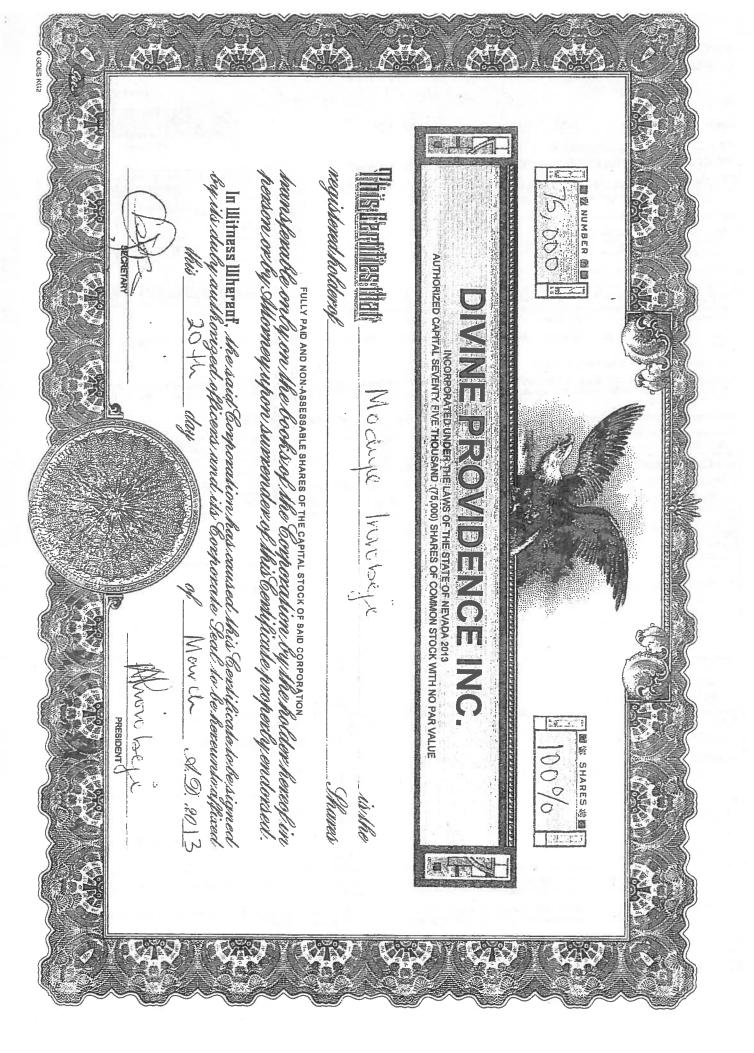
Board Use Only

Received:

Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

<u>OW</u>	NERSHIP IS A NON-PUBLICY TRADED CORPORATION	
	te of Incorporation: Neugla	
Pare	ent Company if any: N	
Corp	poration Name: Sivine Providence in c	
Mail	ling Address: 11655 Kilkenan Ct	
City	r: has vegas State: NV Zip: 8914 Fax:	
Tele	ephone: 954 66317 5 9 Fax:	
Con	ntact Person: Miduye Ivovobeje	
	1	
For	any corporation non publicly traded, disclose the following:	
1)	List top 4 persons to whom the shares were issued by the corporation?	
1066/	Name Trombeje 11655 Kilkenan Ct. Kis vegas 89	11
	Name Address	! !
	b)	
	Name Address	
	c)	
	Name Address	
	d)	
	Name Address	
reco	TE: All persons who are stockholders must accurately complete a personal history ord form. Download the form from the website under the □New Applications□tab. The forms available under the documents for all types of businesses.	
2)	Provide the number of shares issued by the corporation	
3)	What was the price paid per share? No Par Value	
4)	What date did the corporation actually receive the cash assets?03 12012013	
5)	Provide a copy of the corporation stock register evidencing the above information	



(PROFIT) INITIAL/ANNUAL LIST OF OFFICERS, DIRECTION OF:	CTORS AND	STATE BUSINESS	ENTITY NUME	DED
DIVINE PROVIDENCE INC	e de despeta de la secula seculario, el signición de seculario de secu	٢ - ١١٠٥ كا الله الله الله الله الله الله الله ا	and an order some over the same	
NAME OF CORPORATION	s kilokametás ás uzáktat, a elles upa "ell polomba » és i hubbaro-vel jagopapapa azos i	makun alkun makungalarasahah a 2 kan daksari dadasah sadasakan dasak dasah dasah dasah dasah dasah dasah dasah	E013708201	13-1
FOR THE FILING PERIOD OF MAR, 2019 TO MAR, 2	2020			
USE BLACK INK ONLY - DO NOT HIGHLIGHT			*100103*	
YOU MAY FILE THIS FORM ONLINE AT www.nvsilverflun	ne.gov			
Return one file stamped copy. (If filing not accompanied by order inst stamped copy will be sent to registered agent.)		Filed in the office of Balance Klypoole	Document Number 20190192003-9	97
IMPORTANT: Read instructions before completing and returning this form.		Barbara K. Cegavske	Filing Date and Time 05/01/2019 12:	02 D
 Print or type names and addresses, either residence or business, for all officers and dir. President, Secretary, Treasurer, or equivalent of and all Directors must be named. The teast one director. An Officer must sign the form. FORM WILL BE RETURNED IF UN 	en much he at	Secretary of State State of Nevada	Entity Number E0137082013-	
2. If there are additional officers, attach a list of them to this form.	OIGI4LD.			
3. Return the completed form with the filing fee. Annual list fee is based upon the current authorized stock as explained in the Annual List Fee Schedule For Profit Corporations, penalty must be added for failure to file this form by the deadline. An annual list receive 90 days before its due date shall be deemed an amended list for the previous year.	A \$75.00 ad more than	ABOVE S	ument was filed electron PACE IS FOR OFFICE USI	EONLY
 State business license fee is \$500.00/\$200.00 for Professional Corporations filed pursus form by deadline. 	ant to NRS Chapter 89	9. Effective 2/1/2010, \$100.00) must be added for failure t	lo file
5. Make your check payable to the Secretary of State.				
6 Ordering Copies: If requested above, one file stamped copy will be returned at no add A copy fee of \$2.00 per page is required for each additional copy generated when or accompany your order.	stional charge. To recidering 2 or more file s	eive a certified copy, enclose tamped or certified copies. A	an additional \$30.00 per ce opropriate instructions must	rtification
7. Return the completed form to: Secretary of State, 202 North Carson Street, Carson City	y, Nevada 89701-4201	. (775) 684-5708.		
Form must be in the possession of the Secretary of State on or before the last day of the received after due date will be returned for additional less and penalties. Failure to inclu	m mammala tur sudil atu ta tur .		cepted as receipt date.) For	rms
CHECK ONLY IF APPLICABLE AND ENTER EXEMPTION CODE IN BOX E Pursuant to NRS Chapter 76, this entity is exempt from the business licens NOTE: If claiming an exemption, a notarized Declaration of Eligibility for attach the Declaration of Eligibility form will result in rejection, which could be comporation is a publicly traded corporation. The Central Index Key nutral This publicly traded corporation is not required to have a Central Index Key	te fee. Exemption of m must be attache uld result in late fe	d. Failure to 001	5 76.020 Exemption C Governmental Entity NRS 680B.020 Insuran	
NAME				
MODUPE A IROROBEJE	TITLE(S)	DENT (OR EQUIVALENT	1.00	
ADDRESS		JEINI (OR EQUIVALENT	OF)	
11055 KILKERRAN COURT	LAS VEGAS	a half to be are de trindras de publica to a travellar provides in the destination destadence of the	STATE ZIP CODE	- hader house day
NAME MODUPE A IROROBEJE ADDRESS	TITLE(S) SECRE	TARY (OR EQUIVALEN	T OF)	and the control of th
11055 KILKERRAN COURT	CITY	n ni klaji inali niziri ili mini ko vinake kankonti nazirinovia jenenovi uklavna ni versikan na g	TATE ZIP CODE	
1 FUNCTION ALLERAN COOK I	LAS VEGAS	** haldense. No reto-servi - denter more sprom aus transacques plants at 100, 100, 100, 100, 100, 100, 100, 100	NV 89141	
NAME	TITLE(S)			
MODUPE A IROROBEJE	TREAS	URER (OR EQUIVALEN	T OF)	
ADDRESS	CITY	s	TATE ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	A second	NV 89141	1
NAME	TITLE(S)	This is the state of the state	responses specify to the contract artificial photographic devides de informaciones de la contraction of the	and a same
MOUPE A IROROBEJE	DIREC	TOR		
ADDRESS Jone of the control of the	CITY		TATE ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	which have been an investigated as the second section of the section of t	NV 89141	
None of the officers or directors identified in the list of officers has been identified we exercising the power or authority of an officer or director in furtherance of any unian	After the desired to the second	the state of the s	man and harmonic managements.	ns .

i declare, to the best of my knowledge under penalty of perjury, that the information contained herein is correct and acknowledge that pursuant to NRS 239.330, it is a category C felony to knowledge any false or torged instrument for filing in the Office of the Secretary of State.

X MODUPE A IROROBEJE	Title	Date
Signature of Officer or	PRESIDENT In solida to all the security and all the number of small states (1901) and the security and the	5/1/2019 12:03:14 PM
Other Authorized Signature		Nevada Secretary of State List Prof

Nevada Secretary of State List Profit Form: 100103 Revised: 7-1-17





NEVADA STATE BUSINESS LICENSE

DIVINE PROVIDENCE INC

Nevada Business Identification # NV20131166246

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on May 1, 2019

Barbara K. Cegavske Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law <u>cannot</u> be waived.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date

4/10/19

Each MDEG shall employ an administrator at all times. The administrator must be:

- 1. A natural person.
- 2. Have a high school diploma or its equivalent.
- 3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
- 4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
- 5. Be approved by the board.
- 6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for	Medical	Supph	1			
Providence	e Medical	Vature of MDEG	1729	E Charleshin	Blud	ĦF
Name an	d Address of Business	s for Which MDEG	Administra	tor Is Requested	8911	04
	If applicable, Name	Under Which It Is	Now Opera	ated	••	•

	INFORMATION:					
Ivorobe	je	Moduy	L		Ajok	٩
Last Name	2	First Name			Middle Na	ne
	Braithwaite					
Alias(es, Nicknam	nes, Maiden Name, Oth	er Name Cha	inges, Legal	or Othe	rwise)	
	Kilkman	u	Las ve	20,02	NV	89141
Present Residence	ce Address-Street or RF	-D	City			te/Zip
1729 E Ch	chushn BhicDates		165 vec	jas	W	89104
Present Business	Address		City		Sta	te/Zip
Admin	istrator Dates	2013-	Presen	(-		
Present Position	with the MDEG					
Phone: <u>762</u>	982 6678	Fax:	762	485	6332	
Email address: _	982 6678 Providence n	redial Sn	ruly 1 @	0) gw	rail. Co	m
- 21-11-14	Lo	of Birth (City)	gerig)		
Date of Birth	Place	of Birth (City)	County, Sta	ite)		
39					F	
Age	Social	Security Nur	nber		Sex	
Brems	Black	17	0		513 m	
Color of Eyes	Color of Hair	Weigl	nt		Height	
Soors tattoos or	distinguishing marks ar	nd/or charact	prietics	N.	5VL	
Scars, lattoos of	distriguishing marks ar	Id/Of Charact	J1134103			
Are you a citizen	of the United States?	Yes ☑No □			•	
If alien, registration	on No					
If naturalized, cer	rtificate No,		_ Date	02/2	2 2013	
Place Las	s Vegas N	V	(If naturali	zed. doc	cument mus	t be verif

Page 2

MDEG Administrator

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

. 1)	DI Las vegas N 89	1154
2013 - Present	Providence Phamay	45 hous W
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Phamacist	Venjochin Medicalins & Description of Duties Syphics to partie	Maduel I nows
Title	Description of Duties Synthes to party	Name of Supervisor
	Mars 1	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

	osed or treated in the last five years for a mental illness y ability to perform any of the essential functions of my use,
1. I have □ I have not □ been charg	ged, arrested or convicted of a felony or misdemeanor.
2. I have □ I have not □ been the s pending.	ubject of an administrative action whether completed or
3. I have ☐ I have not☐ had a licendisciplined, including any action aga	ise suspended, revoked, surrendered or otherwise inst a professional license that was not made public.
If you checked ☐ have ☐ to questions 1, 2 are provide a written explanation and/or documents.	nd/or 3, please include the following information <u>and</u> nents.
a) Board Administrative Action:	State:
b)	Date:
	Case Number:
c) Criminal Action:	State:
	Date:
a	Case Number:
	County:
	Court:
4. Will you be actively involved in and operation of the MDEG?	d aware of the daily Yes ☑ No □
5 .Will you be employed fulltime with	the MDEG? Yes No 🗆
6 .Will you be present at the site of th during its normal operating hours?	e MDEG Yes ☑ No □
If you answer No to questions 4, 5 or 6 ple	eas explanation.
	···· HOTOGRAPH
	WITHIN LAST
	'S HERE
	Date of photograph 4 29 19

Page 4 MDEG Administrator

I, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant Thas obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent, and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 4/15/19

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made herein is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be

withdrawn without the permission of the licensing agency.

Application for DM 6	= (MDEG)		
Providence Medical	Swilly TLG E (nortishm Blud #F	las vegs 89104
	dress of Establishment for Which License Is F	Requested	
lf арр	olicable, Name Under Which It Is Now Operate	ed	
1. PERSONAL INFORMATION:	Moduje	Apple	
Last Name Braithwaite	First Name	Middle Name	
Alias(es, Nicknames, Maiden Name, Other Name Ch	anges, Legal or Otherwise)	0.0441	
Kilkervan co	us vegas	W 89141	
	rd City Jas Vegas	State/Zip Sello 4	
Present Business Address	ates 2013 - Me Sent	State/Zip	
Occupation		Phone: Residence	
_ i _ i	Lagos, Nigeria	Business 702-982-	-0078
Date of Birth PI	ace of Birth-(City, County, State)	female	
Age Social Secul Back	rity Number BIGCIC IN	Average 5'3"	
Color of Eyes Color of Hair	Complexion Weight	Build G Height	_
Scars, tattoos or distinguishing marks and	/or characteristics	Nou	
Are you a citizen of the United States? Y		4 1	
If naturalized, certificate No.	100 1 Date	2/22/2013	
Place Las Vegas	(If naturalize	d, document must be verified.)	
2. MARITAL INFORMATION:			
Single ☐ Married ☑ Separated	□ Divorced □ Widowed □	Engaged	
10		Applicants initial 1994	
		друпоанца ппцаг	Page 1

MARI	TAL INFORMATION	1	1				
Α.	Current Marriage	12/1	3/2607		Jas veg	as charle,	NV
	Spouses full name	Dat (Maiden)	· Friday lic	nobeji	City, County S.S. No	End Chain	25
	Date of Birth		Place	of Birth	yahelli,	Nigeria	
	Resident address	Street	Glawan	City	as ve	Nigena Jas NV 80	1141
	Telephone: Resid	lence ·	1- 1	Business	70294	5 4262	
	Spouse s employe	, Health Co	me Partue	VS Occupation	n Nurse	5 4262 Practition	~
	Address of employ	er 82 Street	N Nelli	S BW	d Lag v	reas Me	9110
B. P	revious Marriages:					.	
		ate of Order	Date of Place		ature of Ci		=
Name	of Spouse	or Decree	of Marriage		Action Co	ounty and State	-
		Λ. (). (
		NH					_
-							<u> </u>
	List of names, curr Name	ent address and to Street	telephone number: City		spouses:	Telephone	
			NA				(1)
	ψ,						_
3 F/	AMILY INFORMATION)N·					
Α.	Children and Dep	endents:					
	Name	n, including step- Birth Date	children and adopt Birth Place	ted children a	and give the follow Residence A	wing information:	
Den	emiah Iron	beji -	- Las v	egas N.	V	Kilkuvan	ut. Iww
Dal	rene your In	ranbeji.	1 1	1)	1)		
<i>b</i> _G	henevum =	Inonoberi	1	71	7)		
В.	Child Support Info	ormation:					any department of the second o
		rk the appropriate	e response:				
	1 am no	t subject to a cou	irt order for the sup	port of child.			
	plan ap	proved by the dis	rder for the suppor strict attorney or oth suant to the order;	ner public age	ore children and ency enforcing th	am in compliance wi e order for the repay	th a ment
	the orde	er or a plan appro	rder for the suppor oved by the district ount owed pursuar	attorney or o	ther public agend		er for
						l	Page 2

FAMIL	Y INFORMATION-Continued District attorney or public agency	responsible for	enforcing the child s	support order:		
			1.0			
	Name		V 1117			
	Address Contact parson		101	•		
C.	Contact person		-	•••••		
C.	Parents: List names, residence addresses	, dates of birth a	nd most recent occ	upations of parents,	step-parents.	
parents	S-				, , , ,	
	in-law or legal guardian. If retired Name (Maiden) Birth		st last address and Address	occupation.	Occupation	
Father		•				
Bar	nkole. Braiken	saile		Deceased	<u> </u>	
Mother	Ti		1 *: 110	s . 1	6.0	D. 10. 1
leal	ia thomas	•	Killuna	n U- 195	Vegers 89141	Kenney
Father-in	-Law	5 0	Ala Vi		1	Kelthei
100	Chall troubey		whothere	St. Ughe	eli North D	relta stau
Mother-in		7	ALA. 11.12	St. Ughell	11 10 No1	tening
MV	que trombeje		KINGGICHE	SI Ughella	100000 300	1-11 2 10-CC
D.	Brothers and Sisters: List names, residence addresses	s, dates of birth a	and most recent occ	upations of brothers	and sisters and of	
	their respective spouses. Name (Maiden)	Birth Date	Address		Occupation (. د/
NA.	Sharloin forcaili	/	11	· Mic.	Drive 331	sema
Spouse	380 (W) 10 MM.	air	1			
<u>PZ'</u>	hig torculture	outi		Man	- brive 33	16 2 House
_						mls
Spouse						
	The Mercel of					
Canusa						
Spouse						
Spouse						
4. E	DUCATION:					
	Name of School	Location	Dates Attende	ed	Graduate	
Gramma School	"Mangland lower	it Imma	my school	1985-1991	Yes 🖾 No 🗆	
High	Manager A Command	Lha. Cair	Sec. Schus	P 1991-1997		
School College	TI On III	(1)	300	2 11 11 11 1	Yes No 🗆	
Universi	1 1001101	mal y	musel)	Yes No 🗆	
<u>Other</u>	Mani yard	ms 1-1	28074	_	Yes 🛛 No 🗆	
Type o	of degree obtained, if any	, Phan	/m-12	2007-2010	<u></u>	
	e or university where obtained	Kosemi	in Colli	ge of Item	1th Scren	ice
	1	1 Semse	e way	hunderson	W 860	14
			7	Applicants initial	IVVI	
					Page	e 3

5 MILITARY INFORMATION:

A.	Have you ever served in any armed forces? Yes □ No □
	BranchDate of entry-active service
	Date of separationType of discharge
	Rating at separationSerial number
	While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes □ No □ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)
В.	Have you registered for the draft? Yes □ No ℚ
	CountyStateDate registered
6. A	RRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were
A.	not convicted.) Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes No V If yes, give details in space provided below. List all cases without exception.
Date of	Arrest Age Charge Location-City and State Deposition/Date Arresting Agency
	1
В.	Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes □ No □ If yes, furnish details on page 10.
C.	Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes No
D.	Have you ever been subpoensed to appear or testify before a federal, state or county grand jury, board or commission? Yes No 12
E,	Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing?
F.	Yes \(\text{No } \(\text{V} \) Have you ever had a civil or criminal record expunged or sealed by a court order? Yes \(\text{No } \text{V} \)
G.	If yes, when? city, county and state Have you ever received a pardon or deferred prosecution for any criminal offense? Yes □ No ☑
H.	If yes when?city, county and stateHas any member of your family or of your spouses family ever been convicted of a felony? Yes Delay No Use If you answer to any of the above questions (B through H) is yes, furnish details on page 10.
Name	Relationship Charge Location Date
	NR
	Applicant is initial 1994
	Page 4

Page 5

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

part to Yes	a lawsu No 🗆	it as either (Other tha	a plaintiff or n divorces)	defenda	nt or an a	r owner, direct arbitration as on, including	either a c	laimant or i	poration espon	on. ever be dent?	en a
Plaintiff/Defendan		Date Filed		and Case		City, County a	and State		Dienos	ition/Date	
Alferra	lan milto		2/2010	13-47-4	6337	-MKn	1	Vegos		7/21	2010
J. Has a	ny gener					oprietorship o					
			wner, officer		r or partn	er) been a pa				or bankrupi	:cy?
Name o	of Entity		Туре	of Entity				oximate Date(uit/Arbitration/		ptcy	
					11 (•
	*					11/					
7. RESIDEN	NCES:			i a II =0	1						
List all resider	nces you	have had f	or the last 2	5 years:						(6)	
Month and Year (From-To)		1	treet and Numl		2 / 14	City		State or		2 x > G	-
18 DUGS		8/2007	1868		3011 N 15	s kuno	#36			3029 F1 2	2NCU
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							Applica	nts initial_		MH	-

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year 12513 - 04/19	Name/Mailing Address of Employer/Business Phon dence Phomacy	Reason for Leaving
Title Thamas St	Description of Duties Commander Manager	Name of Supervisor Abdupe Musby
Month and Year OI 12 -08 14 Title Dicum 998	Name/Mailing Address of Employer/Business Waltwart Phamay Description of Duties ' Phamay GST	Reason for Leaving Ly + by by by Situs S Name of Supervisor
Month and Year 10 2616 - 612 Title Marman St	Name/Mailing Address of Employer/Business OL CVS MCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC	Reason for Leaving Suithed Companies Name of Supervisor Knowd a Lond & ford
Month and Year OH 254 - 10 Title Phamayst	Description of Duties	Reason for Leaving May Part Lun Name of Supervisor Negro W 89119
Month and Year <u>05/2005</u> Title (UShown Ser	Name/Mailing Address of Employer/Business 64206 6 Interaction Responses Description of Duties 2969 N. Communication of Dutie	Reason for Leaving Humby gy Name of Supervisor Chair june Semus
Month and Year OS 1998 Title	Name/Mailing Address of Employer/Business — Of Duties Description of Duties	Reason for Leaving Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
If additional space is n	eeded, continue on page 10 or provide attachment.	

Applicant is initial....

9. CHARACTER REFERENCES:

	List five character reference who have know you five years	or more. Do no	t include relatives	, present
Name of	employer or employees. Where Employed Street City State Zip	Telephone	Yea	ars Known
Name 1	Home C. D.	Ranch A	ne 89052.	7 years
Employe	r NIA Business 'NIA	2.5		
Name F	Tione	Ami 89	128	10 years
Employe	Findred Abspausiness 5110 W Sahara	x has v	egas	
Name 4	2eb/gek/le/Home 5 Rounbows 1	0 - 10 - 1	10 8945 11	0 years
Employe	Alpha & Albusiness 222 S Rambe	son gra	4 110 8914	15
Name	Rose Stiffinnome, NW 4 dr.	d Brems	. 1733054 /	6 years
Employe	Thorda Um Business University hope	88n	78729	
Name_	Armelle Wedva Go 3 hunter	Chase by	# 424 13	years
Employe	State of Texa Business Accounting			
10.	Do you have any safe deposit box or other such depositor	y, access to any	depository or do	you use any other
	person's depository? Yes \(\square\) No \(\square\) If yes, complete the following:			
Box Num	nber or Type of Depository Location City and Sta	ate A	uthorized Users	
		\		
		()		
	V			
				A second of the first terms in the second of
11.	Have you ever held a privileged, occupational or profession the following:	nal license in an	y state, including	but not limited to
	Liquor Lawyer Race horse/race dog owr		Securities dealer	Insurance
	Doctor Contractor Real estate broker or sale Accountant Pilot Sports promoter		Barber/Cosmetolograiner or manage	
	Yes □ No □	•	rainer of manage	Zuddatoi
	If yes, state type, where and years held			
	,			
	<i>k.</i>)	14		
	1/2	\ **		•••••
12.	Have you ever applied for a city, county of state business,	venture or indus	stry license or help	d∕a financial
	interest in a licensed business or industry OUTSIDE the S	state of Nevada?	Yes □ No ☑	
	If yes, state type, when and where and give names and lo involved, the names and address of all partners and the a			
	venture or industry.	5	J	•
		A		
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		App	licants initial	1 7 1
	Part Control of the C			Page 7

13.	any reason whatsoever? Yes □ No □	ency or similar authority in or outside the State of Nevada for
14.	Have you ever been denied a personal license, per or professional activity? Yes ☐ No No	ermit, certificate or registration for a privileged, occupational
If yes	o the above, state where, when and for what reaso	n:
15.	Have you ever been refused a business or industreparticipant in any group which has been denied a suitability?	ry license or related finding of suitability or been a business or industry license or related finding of Yes No Yer
16.	Have you or any person with whom you have bee administrative action or proceeding relating to the	n a participant in any group been the subject of an pharmaceutical industry? Yes □ No 🖼
17.	Have you or any person with whom you have bee guilty or entered a plea of nolo contendere to any controlled substances?	n a participant in any group ever been found guilty, plead offense, federal or state, related to prescription drugs and/or Yes □ No □
18.	Have you or any person with whom you have bee permit or certificate of registration relating to the pupon voluntary close of a manufacturer	n a participant in any group ever surrendered a license, harmaceutical industry voluntarily or otherwise (other than Yes □ No □
19.	Do you have any relatives within the fourth degree pharmaceutical or drug related industry?	e of consanguinity associated with or employed in the Yes □ No □
		Date of photograph 42919 Applicant is initial
		Page 8

STATE OF Nevada
SS.
COUNTY OF CIGVIC I, Modupl - Yorkbyi , being duly sworn, depose and say I have read the
1, Moduft - 1005 by , being duly sworn, depose and say I have read the
foregoing application and know the contents thereof; that the statements contained herein are true and correct and
contain a full and true account of the information requested; that I executed this statement with the knowledge that
misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of
a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised
Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license,
registration or permit if the holder or applicant (Has obtained any certificate, certification, license or permit by the filing
of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent, Eand
further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the
Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as
promulgated thereunder and agree, if licensed, to abide thereby,
I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their
agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors
can, shall or may have against the State of Nevada, the licensing agency and their agents, as a result of my applying
for a manufacturer license in the State of Nevada.
Original Signature of Applicant
Subscribed and Sworn to before me this 15th day of May 2019 MARIAM JANE N. HASSO Notary Public, State of Nevada Appointment No. 15-2958-2 My Appt. Expires Jun 8, 2019 Notary Public

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ADDITIONAL INFORMATION

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