12

12A

4/3

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. Eastern 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: LV State: NV Zip Code: 89119

Telephone: 702-480-5617 Fax: _____

E-mail: alltimehealthcare@gmail.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5PM Tue: 9am to 5PM Wed: 9am to 5PM Thu: 9am to 5PM

Fri: 9am to 5PM Sat: 9am to 5PM Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Angelica Gutierrez

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: Incontinence & disposable supplies

**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 all Medicare and Medicaid provider numbers registered to the business or its owner:

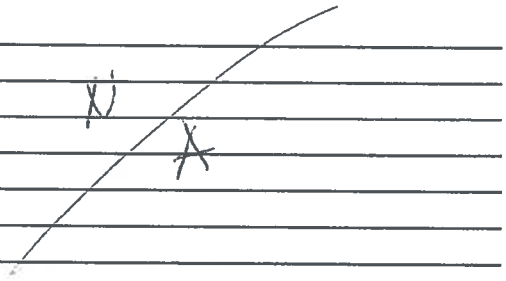
Medicare	In process	
Medicaid	In process	

1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☐ No ☑

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☑

3) Are any of the owners health professionals? If yes, please check the box and list name.

- ☐ Practitioner — Name:
- ☐ Advanced Practitioner of Nursing — Name:
- ☐ Physician's Assistant — Name:
- ☐ Physical Therapist — Name:
- ☐ Occupational Therapist — Name:
- ☐ Registered Nurse — Name:
- ☐ Respiratory Therapist — 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.

Within the last five (5) years:

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 ☑

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

Dailin Carmenate Arias — 3/27/19

Print Name of Authorized Person — Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.

Owner's Name: Dailin Carmenate Rivas

Business Name: all time Health care

Current Business Address: 4660 S Eastern Ave ste# 100

City: LV State: NV Zip: 89119

Telephone: 702-480-5617 Fax: _____

SOLE OWNER

Include with the application for a sole owner

Complete personal history record 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

STATE OF NEVADA

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

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 cannot be waived.

SECRETARY OF STATE

STATE OF NEVADA

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.

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

Barbara K. Cegavske
Secretary of State

Certified By: Electronic Filing
Certificate Number: C20190327-1751

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 3/22/19

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'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

Alltime Health care 4660 S. Eastern ave ste 100 LV NV 89119

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Gutierrez — Last Name
Angelica — First Name
Middle Name

N/A
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Spring Rain Rd — Present Residence Address-Street or RFD — Las Vegas — City — NV 89142 — State/Zip

4660 S. Eastern Ave. Suite 100 — Present Business Address — Dates 4/1/19 — Las Vegas — City — NV 89119 — State/Zip

Administrator — Present Position with the MDEG — Dates 4/1/19 - Present

Phone: [redacted] Fax: _____

Email address: Alltimehealthcare19@gmail.com

[redacted] — Date of Birth
Las Vegas, USA, NV — Place of Birth (City, County, State)

22 — Age
[redacted] — Social Security Number
F — Sex

Brown — Color of Eyes
Brown — Color of Hair
120 — Weight
5'0 — Height

Scars, tattoos or distinguishing marks and/or characteristics _____

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

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.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Jan 2017-2019	Touro Health Center 874 American Pacific Dr NV. 89104	(3840)
Title	Description of Duties	Name of Supervisor
Front office receptionist		Tina Galendo
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
September 2015- Jan2017	Cima Medical Center 3115 S. Eastern Ave. LV NV 89169	3840
Title	Description of Duties	Name of Supervisor
Front office receptionist		Patricia Webb.
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
March 2013 – Sep. 2015	Quick Care Las Vegas 3111 S. Maryland Pkwy 89169 LV NV	3840
Title	Description of Duties	Name of Supervisor
Front office receptionist & Billing		Mario Targuilino
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

I have ☐ I have not ☑ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☑ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☑ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☑ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____
Case Number: _____

c) Criminal Action: State: N _____
Date: A _____
Case Number: _____
County: _____
Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☑ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☑ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☑ No ☐

If you answer No to questions 4, 5 or 6 please provide a written letter of explanation.

.....

.....

.....

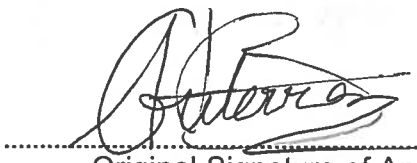
.....

.....

Date c 3/11/2019

I, Angelica Gutierrez, 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 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 Durable Medical Equipment
Nature of License

Alltime Healthcare 4660 S. Eastern ave ste 100 LV NV 89119
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Carmenate Rivas	Wailin	

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Present Residence Address-Street or RFD	City	State/Zip
N/A	Rosarito, Las Vegas,	NV 89121 -
2840 E. Flamingo Rd Dates	Las Vegas	NV 89121
Present Business Address	City	State/Zip

Owner Dates
Occupation

Phone: Residence

Business

Date of Birth / Las Tunas, Cuba
Place of Birth (City, County, State)

33 Female
Age Social Security Number Sex

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Black	Brown		172		5.3

Scars, tattoos or distinguishing marks and/or characteristics N/A

Are you a citizen of the United States? Yes ☑ No ☐ If alien, registration No ~~11/17/2006~~ N/A

If naturalized, certificate No Date 11/17/2006

Place Las Vegas, Nevada (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial DCR

MARITAL INFORMATION-Continued

A. **Current Marriage** 2/20/2005 (Date) Las Vegas, NV USA (City, County and State)

Spouse's full name (Maiden) Ohan Deivys Gutierrez S.S. No. -

Date of Birth , , Place of Birth Cardenas, Matanzas Cuba

Resident address Rosario Cir (Street) Las Vegas (City) NV (State) 89121 (Zip)

Telephone: Residence , Business

Spouse's employer Self Employ Occupation Driver

Address of employer Amazon Delivery (Street) Las Vegas (City) NV (State) (Zip)

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
N/A				

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
Nilieth Gutierrez	, ,	USA	Rosario Cir LV NV
Keilyn Gutierrez	, ,	USA	Rosario Cir LV NV
Angelica Gutierrez	, ,	USA	Spring Rain Rd LV NV

B. Child Support Information:

Please mark the appropriate response:

☑ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial DCR

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, step-parents, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Norberto Carmenate Sanchez	/ /		Deceased.
Mother	Margarita Rivas Acuña	/ /	Palora Ave LV. NV 8911	
Father-in-Law	Enrique Ramirez Pelegrin	/ /	Palora Ave LV NV 89169	
Mother-in-Law				

D. Brothers and Sisters:

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
	Deyker Carmenate Rivas	/ /	Palora Ave LV NV	Packer.
Spouse	Yoilin Torres Guerra	/ /	Same Address	Unemploy.
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	El Dorado Highschool	Las Vegas, NV	1999/2003	Yes ☐ No ☑
High School	Valley Highschool	Las Vegas NV		Yes ☐ No ☑
College University	Las Vegas College	Las Vegas. USA!	2003/2005	Yes ☑ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any Bookkiping

College or university where obtained Las Vegas college.

Applicant's initial DCR.

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☐ No ☑

Branch.....Date of entry-active service.....

Date of separation.....Type of discharge.....

Rating at separation.....Serial 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.)

B. Have you registered for the draft? Yes ☐ No ☑

County.....State.....Date registered.....

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. 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 ☑ 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

B. 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 subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☑

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☑

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☑
If yes, when?.....city, county and state.....

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☑
If yes when?.....city, county and state.....

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☑
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial.....

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?
Yes ☐ No ☑ (Other than divorces)
If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date

J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
Yes ☐ No ☑ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
12/2013 - Present	Rosario cir	Las Vegas,	Nevada USA
12/2012/12/2013 -	? Aracatuba Ave	Las Vegas,	Nevada USA
2013 - 2013	2900 Olive St Apt 11	Las Vegas	NV USA
2009 - 2011	500 S. Maryland Pkwy	Las Vegas	
2005 - 2009	1924 Golden Arrow Dr	LV	NV 89169
1990 - 2005	4801 Lakestream Ave	LV	NV 89

Applicant's initial DCR

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	Express Tax Services 2840 E. Flamingo Rd	Owner. n/A.
Title	**Description of Duties**	**Name of Supervisor**
Owner	tax preparer -	Self.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2019 to 04/2017	At your Services Home Care. 1785 E. Sahara Ave LVNV	No more client
Title	**Description of Duties**	**Name of Supervisor**
Personal Care	Visit client help w/daily Basic.	Fernando.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2014/04-17.	AM/PM Home Care 820 Rancho LN LV NV 89106	Better Salary.
Title	**Description of Duties**	**Name of Supervisor**
Personal Care	Visit clients help w/daily Care Basic.	—

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
06/2005/-12/2013	The Venetian Hotel 3355 S. LV Blvd.	Looking for a better business
Title	**Description of Duties**	**Name of Supervisor**
Attendent	Restock mini Bar in Hotel Rooms.	See Bastian.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/18-Present	Allstate Ins. 3265 E. Tropicana Ave	still employed.
Title	**Description of Duties**	**Name of Supervisor**
Sales	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
Title	**Description of Duties**	**Name of Supervisor**

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

Applicant's initial DCR.

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Leandro Ramirez (Wynn Hotel)	Home	Palomino LV	NV	89169	:	10+.
Employer Wynn Hotel	Business 3131 S. Las Vegas Blvd				702-770-7000	10+
Name Laura Senda	Home : Bel Port Dr			89110		5½+
Employer All State Ins	Business 3265 E. Tropicana Ave E-1	LV	NV			
Name Yolanda Citto	Home ' Montagna Dr	LV	NV	89134		6 years
Employer Allstate Ins	Business 3265 E. Tropicana Ave E.1	LV	NV		702 908-7450	
Name Yusimi Befarte	Home E. Imperial Ave	LV	NV	89104		10 years
Employer Amazon Delivery	Business					
Name Yosbel Fariñas	Home E. Imperial Ave.					
Employer Self Employed	Business Self employed					6 years

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	(Insurance)
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☑ No ☐
If yes, state type, where and years held

Sales Insurance . Las Vegas, NV 1/24/2017

✓12. Have you ever applied for a city, county of state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☑ No ☒
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

Soleproper- Express tax Services- Las Vegas, NV
Tax Preparation Preparer - 2015 - Present.
2840 E. Flamingo Rd Suit C Las Vegas, NV 89121

Applicant's initial DCR.

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☑

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

If yes to the above, state where, when and for what reason:

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☑

16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☑

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

A1

Date of photograph 3/11/19

Applicant's initial DCR

STATE OF Nevada
ss.
COUNTY OF Clark

I, Dailin Carmenate 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
County of Clark

X
Original Signature of Applicant

Subscribed and Sworn to before me this 28th day of March 2019

Dailin Carmenate-Rivas

Notary Public

JOHN ACEVES
Notary Public - State of Nevada
County of Clark
APPT. NO. 08-7219-1
My App. Expires Sep. 1, 2020
(seal)

Applicant's initial DCR

ADDITIONAL INFORMATION

Applicant's initial DCR

12B

4:12

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: Otto Bock Orthopedic Services LLC

Physical Address: 2780 S. Jones Blvd Ste 140 Las Vegas, NV 89146-5641

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 11501 Alterra Pkwy Ste 600 - Attn Jessica Salatino

City: Austin State: Texas Zip Code: 78758-3597

Telephone: 512-806-2628 Fax: 866-642-2302

E-mail: US-OS-NPRC-Department@ottobock.com. Website: www.ottobockus.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: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Sharon Clark

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: Tim Alonzi Telephone: 248-470-5413

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

MEDICARE #
AZ- 633760003Y
CO - 633760 0009
FL- 63376000 27
IL- 63376000 33
MD- 6337600037
MI- 6337600029
NC- 633760 00 30

MEDICARE
OH- 6337600032
OK- 6337600036
PA- 6337600031
TX- 6337600001
TX- 6337600018
UT- 6337600035

MEDICAID
AZ- 44552-5
WI - 10004351 0
OK- 2000 49510 D
MI- 8668690
PA- 102409 3690004
MD- 0332691
TX- 2119 14103
UT- 3009687
NC- 1104206 499

1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☐ No ■

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ■ No ☐

3) Are any of the owners health professionals? If yes, please check the box and list name.

☐ Practitioner	Name: N/A
☐ Advanced Practitioner of Nursing	Name: N/A
☐ Physician's Assistant	Name: N/A
☐ Physical Therapist	Name: N/A
☐ Occupational Therapist	Name: N/A
☐ Registered Nurse	Name: N/A
☐ Respiratory Therapist	Name: N/A

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.

Within the last five (5) years:

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 ☒

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

Danilo Sarria
Print Name of Authorized Person

4/09/19
Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Minnesota

Parent Company if any: Otto Bock HealthCare North America INC.

Corporation Name: Otto Bock HealtHcare North America INC.

Mailing Address: 11501 Alterra Pkwy Suite 600

City: Austin State: Texas Zip: 78758-3597

Telephone: 800-328-4058 Fax: 866-642-2302

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

b) _____
Name Address

c) _____
Name Address

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. See attached

3) What was the price paid per share? " "

4) What date did the corporation actually receive the cash assets? " "

5) Provide a copy of the corporation's stock register evidencing the above information

APPLICATION FOR NEVADA MDEG LICENSE

NON PUBLICLY TRADED CORPORATION

Include with the application for a non publicly traded corporation

Complete personal history record 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*.

Certificate of Corporate status (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, Otto Bock Orthopedic Services LLC (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 78758**
Principal Executive Office Address		**11501 Alterra Parkway Suite 600 Austin TX 78758**
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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 3/29/19

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'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, Prosthetics, Orthotics, and Supplies
Nature of MDEG

Otto Bock Orthopedic Services LLC - 2780 S. Jones Blvd., Suite 140, Las Vegas, NV 89146-5641
Name and Address of Business for Which MDEG Administrator Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Hamilton (Last Name) | Irma Gloria (First Name) | (Middle Name)

Irma Gloria Peralta, Gloria Hamilton
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Autumn Haze (Present Residence Address-Street or RFD) | Las Vegas (City) | NV 89117 (State/Zip)

2780 S Jonas Blvd, Suite 140 (Present Business Address) | Dates | Las Vegas (City) | NV 89146 (State/Zip)

Service Center Administrator (Present Position with the MDEG) | Dates

Phone: 800-736-8276 Fax: 866-632-2303

Email address: US_OS_NPRC_Department@ottobock.com

(Date of Birth) | San Diego, San Diego, CA (Place of Birth (City, County, State))

61 (Age) | (Social Security Number) | F (Sex)

Brown (Color of Eyes) | Brown (Color of Hair) | 145 lbs (Weight) | 5'4" (Height)

Scars, tattoos or distinguishing marks and/or characteristics None

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No _____

If naturalized, certificate No_____ Date _____

Place_____(If naturalized, document must be verified.)

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	Name/ Address of Employer/Business	No of Employed Hours
Medical Billing Mgr	Medical Billing and Claims	Kristie Niang
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

I have ☐ I have not ☒ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not☒ been charged, arrested or convicted of a felony or misdemeanor.

2. I have ☐ I have not ☒ been the subject of an administrative action whether completed or pending.

3. I have ☐ I have not☒ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action:
b)

State: _____

Date: _____

Case Number: _____

c) Criminal Action:

State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☒ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☒ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☒ No ☐

If you answer No to questions 4, 5 or 6 please provide a written letter of explanation.

.....

.....

.....

.....

.....

AT H

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.

Irma Gloria Hamilton

Original Signature of Applicant

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

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.

Application for Durable medical equipment, prosthetics, orthotics and supplies
Nature of Pharmacy or Wholesaler

Otto Bock Orthopedic Services LLC: 2780 S. Jones Blvd, Suite 140 Las Vegas, NV 89146
Name and Address of Business for Which Designated Representative Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Sarria — Danilo — —
Last Name — First Name — Middle Name

DAN
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Stratus Drive — Dripping Springs, TX 78620
Present Residence Address-Street or RFD — City — State/Zip

11501 Alterra Parkway Suite 600 — Dates — Austin, TX 78758
Present Business Address — City — State/Zip

VP of Operations — Dates
Present Position with the Pharmacy or Wholesaler

Phone:
Residence
Business 480-281-2234

Date of Birth — Place of Birth (City, County, State)

50 — — M
Age — Social Security Number — Sex

BROWN	BROWN	WHITE	215	ATHLETIC	6'2"
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

Scars, tattoos or distinguishing marks and/or characteristics NA

Are you a citizen of the United States? Yes ☑ No ☐ If alien, registration No

If naturalized, certificate No Date 1/15/88

Place PHOENIX, AZ (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial DS

A. **Current Marriage** 2/14/99 (Date) PHOENIX, MARICOPA, ARIZONA (City, County and State)

Spouse's full name (Maiden) CORY L. S.S. No

Date of Birth Place of Birth CEDAR RAPIDS, IA

Resident address 9524 STRATUS DRIVE (Street) DRIPPING SPRINGS (City) TX (State) 78620 (Zip)

Telephone: Residence Business 602-301-8388

Spouse's employer SELF-EMPLOYED Occupation REALTOR

Address of employer 9524 STRATUS DRIVE (Street) DRIPPING SPRINGS (City) TX (State) 78620 (Zip)

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
ROBIN SARRIA	07/1994	PHOENIX AZ	DIVORCE	PHOENIX, MARICOPA, AZ

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone
ROBIN BISHOP	7 FARGO LN	LINCOLN	CA	95648	( )

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
MORGAN LIEBER	/ /	SACRAMENTO, CA	BARNHILL LN LINCOLN CA 95648
EMILY SARRIA	/ /	SCOTTSDALE, AZ	STRATUS DRIVE DRIPPING SPRINGS, TX 7862
JULIANA SARRIA	/ /	SCOTTSDALE, AZ	STRATUS DRIVE DRIPPING SPRINGS, TX 7862
ANA SARRIA	/ /	SCOTTSDALE, AZ	STRATUS DRIVE DRIPPING SPRINGS, TX 78620

B. Child Support Information:

Please mark the appropriate response:

☑ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial DS

District attorney or public agency responsible for enforcing the child support order:

Name N/A

Address

Contact person

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, 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 ANA TOBON	/ /	DECEASED	
Father-in-Law	GEORGE KNOTT II		DECEASED	
Mother-in-Law	BARBARA CORY	- / / ?	15.7TH ST #316 PHOENIX, AZ 85040	RETIRED

D. Brothers and Sisters:

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
N/A			
Spouse			
Spouse			
Spouse			
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	EDISON ELEMENTARY	PHOENIX, AZ	1980-1982	Yes ☑ No ☐
High School	CAMELBACK HIGH SCHOOL	PHOENIX, AZ	1982-1986	Yes ☑ No ☐
College University	ARIZONA STATE UNIVERSITY	TEMPE, AZ	1998-2004	Yes ☑ No ☐
Other	UNIVERSITY OF PHOENIX	PHOENIX, AZ	2004-2009	Yes ☑ No ☐

Type of degree obtained, if any MASTERS OF BUSINESS ADMINISTRATION

College or university where obtained UNIVERSITY OF PHOENIX

Applicant's initial

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☑ No ☐

Branch MARINE CORPS Date of entry-active service 4/88

Date of separation 5/89 Type of discharge HONORABLE DISCHARGE

Rating at separation PFC Serial number [redacted]

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.)

B. Have you registered for the draft? Yes ☐ No ☑ ENLISTED IN SERVICE

County State Date registered

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. 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 ☑ 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

B. 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 subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☑

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☑

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☑
If yes, when? city, county and state

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☑
If yes when? city, county and state

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☑
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial [redacted]

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?
Yes ☐ No ☑ (Other than divorces)
If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date

J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
Yes ☐ No ☑ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
06/2015 - PRESENT	1 STRATUS DRIVE	DRIPPING SPRINGS,	TX
07/2014 - 06/2015	4125 SUGARLOAF DRIVE	AUSTIN, TX	TX
04/2012 - 07/2014	5223 S. BIG HORN PL	CHANDLER	AZ
05/2005 - 04/2012	16654 S. 27TH AVE.	PHOENIX	AZ
05/2003 - 05/2005	2937 W. SILVER FOX	PHOENIX	AZ
10/1999 - 05/2003	455 W. MOUNTAIN SAGE	PHOENIX	AZ
10/1997 - 10/1999	1100 E. OSBORN RD	PHOENIX	AZ
10/1995 - 10/1997	1501 W. VERNON AVE	PHOENIX	AZ
08/1983 - 10/1995	1751 E. CAMBRIDGE AVE	PHOENIX	AZ

Applicant's initial _____

8. EMPLOYMENT:

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.

05/2008 — OTTOBOCK 11501 ALTERRA PARKWAY, SUITE 600 AUSTIN, TX 78758 — 22,880 HOURS
Month and Year — Name/Mailing Address of Employer/Business — Number of Employed Hours

VP, OPERATIONS — EXECUTIVE DIRECTOR OF ORTHOPEDIC SERVICES — 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.

Applicant's initial DS

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Y	K	n
Name JON SCHWARTZ	Home	? E. MARLETTE AVE	PHOENIX,	AZ	85016	40		
Employer STATE OF ARIZONA	Business	AZ SUPREME COURT JUDGE						
Name ANN ADAMS	Home	S. CARRIAGE LN	CHANDLER,	AZ	85286	25		5
Employer REALTOR/BROKER	Business	ANN ADAMS & ASSOCIATES						
Name GEORGE BAXTER	Home	? N LAKE PLEASANT RD	PEORIA,	AZ	85382	37		
Employer U.S. POSTAL SERVIC	Business	POSTAL SUPERVISOR						
Name TEESHA MARTIN	Home	5 E NORTHRIDGE ST.	MESA,	AZ	85213	11		
Employer VALLEY SLEEP CENTER	Business	OPERATIONS MANAGER						
Name ANNE WALMSLEY	Home	BLAIRSVILLE HWY	MURPHY,	NC	28903	8		
Employer ADVANCED ORTHO	Business	DIRECTOR OF SALES (ORTHOTICS)						

10. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☑

If yes, state type, where and years held

11. Have you ever applied for a city, county of state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☐ No ☑
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

12. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☑ No ☐
NEVADA BOARD OF PHARMACY

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

If yes to the above, state where, when and for what reason:
NEVADA BOARD OF PHARMACY MFG LICENSE IN 2010 WHICH WAS APPROVED FOR OUR FORMER LOCATION IN LAS VEGAS

Applicant's initial JS

14. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☑

15. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

16. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☑

17. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a wholesaler Yes ☐ No ☑

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler? Yes ☑ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☑ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes ☐ No ☑

Date of photograph 3/30/19

Applicant's initial DS.

STATE OF Texas
ss.
COUNTY OF Travis

I, DANILO SARRIA, 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 2nd day of April, 2019

Notary Public

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

Applicant's initial

Applicant's initial.....

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

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 License

_____
Name and Address of Establishment for Which License Is Requested

_____
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

SCHULTZ | ANDREAS | LUDWIG
Last Name | First Name | Middle Name

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

PLEASANT PANORAMA VIEW | AUSTIN | TX 78738
Present Residence Address-Street or RFD | City | State/Zip

11501 ALTERRA PKWY | Dates | AUSTIN | TX 78758
Present Business Address | City | State/Zip

CFO | Dates
Occupation

Phone:
Residence _____
Business 6127351172

CELLE, GERMANY
Date of Birth | Place of Birth (City, County, State)

50 | [redacted] | MALE
Age | Social Security Number | Sex

BLUE | BLOND/GREY | FAIR | 220lbs | 6'1"
Color of Eyes | Color of Hair | Complexion | Weight | Build | Height

Scars, tattoos or distinguishing marks and/or characteristics _____

Are you a citizen of the United States? Yes ☐ No ☒ If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial AS

A. **Current Marriage** 12/22/05 (Date)

Spouse's full name (Maiden) GLORIA CONGHUYEN (City, County and State) S.S. No

Date of Birth [illegible] Place of Birth SILVER SPRING, MD

Resident address 1 PLEASANT PANORAMA VIEW AUSTIN TX 78738
Street City State Zip

Telephone: Residence Business

Spouse's employer ✓ Occupation HOMEMAKER

Address of employer ✓
Street City State Zip

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
KAIA SCHULTZ	[illegible]	HOUSTON, TX	1 PLEASANT PANORAMA VW AUSTIN, TX 78738
AXEL SCHULTZ	[illegible]	ZURICH, SWITZERLAND	11

B. Child Support Information:

Please mark the appropriate response:

☒ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial AS

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, step-parents, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	LUDWIG SCHULTZ		1 GÖCKENHOLZ/GERMANY	DECEASED
Mother	EDELGARD SCHULTZ		1 LACHENDORF/GERMANY	RETIRED
Father-in-Law	PHILIP VINH QUOC		0 BEECHNUT #4202 HOUSTON TX 77083	RETIRED
Mother-in-Law	BICH NGOC NGUYEN		0 BEECHNUT #4202 HOUSTON, TX 77083	RETIRED

D. Brothers and Sisters:

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
Spouse	MICHAELA KRUSCHELWSKI		7 CELLE/GERMANY	LAW CLERK
Spouse				
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School				Yes ☐ No ☐
High School	BFBS I	CELLE, GERMANY	1989-1990	Yes ☒ No ☐
College University	FH OFFENBURG	OFFENBURG	1991-1995	Yes ☒ No ☐
Other	UNIVERSITY OF CHICAGO	CHICAGO	2000-2002	Yes ☒ No ☐

Type of degree obtained, if any EXECUTIVE MBA

College or university where obtained U OF CHICAGO

Applicant's initial AS

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☒ No ☐

Branch TANK DIVISION 95 Date of entry-active service 10/01/1988

Date of separation 09/30/1989 Type of discharge REGULAR

Rating at separation ✓ Serial 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.)

B. Have you registered for the draft? Yes ☐ No ☒

County State Date registered

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. 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 ☒ 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

B. 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 subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒
If yes, when? city, county and state

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒
If yes when? city, county and state

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☒
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial AS

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation, ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?
Yes ☐ No ☑ (Other than divorces)
If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date

J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
Yes ☐ No ☒ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
06/25/2016 – CURRENT	PLEASANT PANORAMA VW	AUSTIN,	TX 78738
09/01/2014 – 06/24/2016	14308 SENIA BEND	AUSTIN	TX 78738
06/25/2014 – 08/31/2014	3501 RR 620 #25001	AUSTIN	TX 78738
12/21/2010 – 06/24/2014	17817 63RD AVE N	MAPLE GROVE	MN 55311
04/17/2010 – 12/20/2010	15337 PORCHLIGHT LN	EDEN PRAIRIE	MN 55347
01/18/2008 – 04/16/2010	BERGSTRASSE 22	RUSHORGEN	SWITZERLAND 8810
09/01/2006 – 01/17/2008	5901 EVERGREEN ST.	MIDLAND	MI 48642
07/05/2004 – 08/31/2006	3030 POST OAK BLVD.	HOUSTON	TX 77056
09/01/1998 – 07/04/2004	SCHÖNBÜHLSTR. 10	ZÜRICH	SWITZERLAND 8032
10/01/1993 – 08/31/1998	FEUERGASSE 13	GENGENBACH	GERMANY 77723

Applicant's initial AS

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
01/01/2010	OTTOBOCK HC LP 11501 ALTERRA PKWY #600, AUSTIN, TX 78758	
Title	**Description of Duties**	**Name of Supervisor**
CFO	FINANCIAL + SHARED SERVICES OVERSIGHT	BRAD RUHL
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
01/01/1995	DOW EUROPE SA BACHTOBELSTRASSE 3, CH-8810 HORGEN	BETTER OPPORTUNITY
Title	**Description of Duties**	**Name of Supervisor**
SR. FINANCE MANAGER	ECONOMIC EVALUATION	CECILIA FALCO
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
06/1991-09/1991	UNEMPLOYED	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
01/1991-05/1991	RPC, BREMERWEG 205 29223 CELLE, GERMANY	- UNIVERSITY
Title	**Description of Duties**	**Name of Supervisor**
WORKER	LOGISTICS ACTIVITIES	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
10/1990-12/1990	UNEMPLOYED	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
07/1989-09/1989	UNEMPLOYED	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
08/1986-07/1988	HÖBEL UNGER, CLOSED	COMPLETED APPRENTICE
Title	**Description of Duties**	**Name of Supervisor**
SALESMAN	APPRENTICESHIP TO SALESMAN	DIETER LOWAG
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 AS

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name SANDRA BACA	Home	W. LINDA LN. CHANDLER	AZ	85224		7 years
Employer SEBE	Business	HEALTHCARE				
Name TEESHA MARTIN	Home	E. NORTHRIDGE ST. MESA,	AZ	85213		8 years
Employer VALLEY SLEEP CENTER	Business	HEALTHCARE				
Name AUNE WALMSLEY	Home	BLAIRSVILLE HWY MURPHY	NC	28903		8 years
Employer ADVANCED [illegible]	Business	HEALTHCARE				
Name RALF KRÜGER	Home	[illegible]			WÄDENSWIL	20 years
Employer DOW EUROPE	Business	CHEMICAL				
Name KRIS FISHMAN	Home	SPRINGWATER DR. JUPITER,	FL	33458		9 years
Employer WELLS PHARMACY	Business	HEALTHCARE				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☒
If yes, state type, where and years held

12. Have you ever applied for a city, county of state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☐ No ☒
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

Applicant's initial AS

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

If yes to the above, state where, when and for what reason:

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☒

16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☒

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer Yes ☐ No ☒

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☒

Date of photograph

Applicant's initial AS

STATE OF Texas
ss.
COUNTY OF Travis

I, ANDREAS SCHULTZ, 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.

Original Signature of Applicant

Subscribed and Sworn to before me this 9th day of April, 2019

Notary Public

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

(seal)

Applicant's initial AS

Applicant's initial AS

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.

☑ 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: Providence Medical Supply

Physical Address: 1729 E Charleston Blvd # F Las Vegas 89104

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1729 E Charleston Blvd # F

City: Las Vegas State: NV Zip Code: 89104

Telephone: 702-982-0078 Fax: 702 485 6332

E-mail: Dype6@yahoo.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: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Modupe Ivorobeji

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 all Medicare and Medicaid provider numbers registered to the business or its owner:

1558824607 _____ _____

1154703905 _____ _____

_____ _____ _____

1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes ☐ No ☑

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes ☐ No ☑

3) Are any of the owners health professionals? If yes, please check the box and list name.

☐ Practitioner	Name: _____
☐ Advanced Practitioner of Nursing	Name: _____
☐ Physician's Assistant	Name: _____
☐ Physical Therapist	Name: _____
☐ Occupational Therapist	Name: _____
☐ Registered Nurse	Name: _____
☐ Respiratory Therapist	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.

Within the last five (5) years:

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 ☑

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

MOBUPE IRORO BEJE — Print Name of Authorized Person

4/10/2019 — Date

Board Use Only	Received:	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Corporation Name: Divine Providence Inc

Mailing Address: 11055 Kilkenny Ct

City: Las Vegas State: NV Zip: 89141

Telephone: 9546631759 Fax: _____

Contact Person: Dr. Medupe Ivorobeje

For any corporation non publicly traded, disclose the following:

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

100% a) Medupe Ivorobeje 11055 Kilkenny Ct. Las Vegas 89141
Name Address

b) _____
Name Address

c) _____
Name Address

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*.

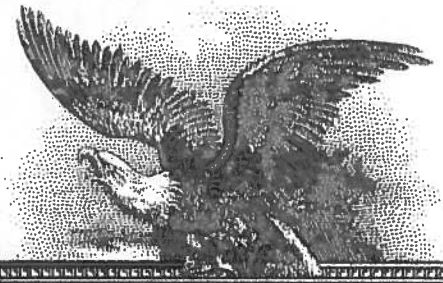
2) Provide the number of shares issued by the corporation. 75,000

3) What was the price paid per share? No Par value

4) What date did the corporation actually receive the cash assets? 03/20/2013

5) Provide a copy of the corporation's stock register evidencing the above information

505



NUMBER 75,000

SHARES 100%

DIVINE PROVIDENCE INC.

INCORPORATED UNDER THE LAWS OF THE STATE OF NEVADA 2013
AUTHORIZED CAPITAL SEVENTY FIVE THOUSAND :(75,000) SHARES OF COMMON STOCK WITH NO PAR VALUE

This Certifies that Modupe Inuwaje is the registered holder of _____ Shares

FULLY PAID AND NON-ASSESSABLE SHARES OF THE CAPITAL STOCK OF SAID CORPORATION

transferable only on the books of the Corporation by the holder hereof in person or by Attorney upon surrender of this Certificate properly endorsed.

In Witness Whereof, the said Corporation has caused this Certificate to be signed by its duly authorized officers and its Corporate Seal to be hereunto affixed this 20th day of March A.D. 2013

SECRETARY

PRESIDENT

© GOES KG2

(PROFIT) INITIAL/ANNUAL LIST OF OFFICERS, DIRECTORS AND STATE BUSINESS LICENSE APPLICATION OF:

DIVINE PROVIDENCE INC
NAME OF CORPORATION

ENTITY NUMBER
E0137082013-1

FOR THE FILING PERIOD OF MAR, 2019 TO MAR, 2020

100103

USE BLACK INK ONLY - DO NOT HIGHLIGHT

****YOU MAY FILE THIS FORM ONLINE AT www.nvsilverflume.gov****

☐ Return one file stamped copy. (If filing not accompanied by order instructions, file stamped copy will be sent to registered agent.)

Filed in the office of	Document Number
Barbara K. Cegavske	20190192003-97
Barbara K. Cegavske Secretary of State State of Nevada	Filing Date and Time 05/01/2019 12:03 PM
	Entity Number E0137082013-1

(This document was filed electronically.)
ABOVE SPACE IS FOR OFFICE USE ONLY

IMPORTANT: Read instructions before completing and returning this form.

1. Print or type names and addresses, either residence or business, for all officers and directors. A President, Secretary, Treasurer, or equivalent of and all Directors must be named. There must be at least one director. An Officer must sign the form. *FORM WILL BE RETURNED IF UNSIGNED.*
2. If there are additional officers, attach a list of them to this form.
3. Return the completed form with the filing fee. Annual list fee is based upon the current total authorized stock as explained in the Annual List Fee Schedule For Profit Corporations. A $75.00 penalty must be added for failure to file this form by the deadline. An annual list received more than 90 days before its due date shall be deemed an amended list for the previous year.
4. State business license fee is $500.00/$200.00 for Professional Corporations filed pursuant to NRS Chapter 89. Effective 2/1/2010, $100.00 must be added for failure to file form by deadline.
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 additional charge. To receive a certified copy, enclose an additional $30.00 per certification. A copy fee of $2.00 per page is required for each additional copy generated when ordering 2 or more file stamped or certified copies. Appropriate instructions must accompany your order.
7. Return the completed form to: Secretary of State, 202 North Carson Street, Carson City, Nevada 89701-4201, (775) 684-5708.
8. Form must be in the possession of the Secretary of State on or before the last day of the month in which it is due. (Postmark date is not accepted as receipt date.) Forms received after due date will be returned for additional fees and penalties. Failure to include annual list and business license fees will result in rejection of filing.

CHECK ONLY IF APPLICABLE AND ENTER EXEMPTION CODE IN BOX BELOW

☐ Pursuant to NRS Chapter 76, this entity is exempt from the business license fee. Exemption code: ☐

NOTE: If claiming an exemption, a notarized Declaration of Eligibility form must be attached. Failure to attach the Declaration of Eligibility form will result in rejection, which could result in late fees.

NRS 76.020 Exemption Codes
001 - Governmental Entity
006 - NRS 680B.020 Insurance Co

☐ This corporation is a publicly traded corporation. The Central Index Key number is:

☐ This publicly traded corporation is not required to have a Central Index Key number.

NAME	TITLE(S)			
MODUPE A IROROBEJE	PRESIDENT (OR EQUIVALENT OF)			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	
NAME	TITLE(S)			
MODUPE A IROROBEJE	SECRETARY (OR EQUIVALENT OF)			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	
NAME	TITLE(S)			
MODUPE A IROROBEJE	TREASURER (OR EQUIVALENT OF)			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	
NAME	TITLE(S)			
MOUPE A IROROBEJE	DIRECTOR			
ADDRESS	CITY	STATE	ZIP CODE	
11055 KILKERRAN COURT	LAS VEGAS	NV	89141	

None of the officers or directors identified in the list of officers has been identified with the fraudulent intent of concealing the identity of any person or persons exercising the power or authority of an officer or director in furtherance of any unlawful conduct.

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 knowingly offer any false or forged instrument for filing in the Office of the Secretary of State.

X MODUPE A IROROBEJE
Signature of Officer or Other Authorized Signature

Title PRESIDENT

Date 5/1/2019 12:03:14 PM

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

SECRETARY OF STATE

STATE OF NEVADA

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

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 cannot 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 associates 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 Supply
Nature of MDEG

Providence Medical Supply 1729 E Charleston Blvd #F 89104
Name and Address of Business for Which MDEG Administrator Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Irorobeje | Modupe | Ajoke
Last Name | First Name | Middle Name

Braithwaite
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Kilkenny Ct | Las vegas | NV 89141
Present Residence Address-Street or RFD | City | State/Zip

1729 E Charleston Blvd HF Dates | las vegas | NV 89104
Present Business Address | City | State/Zip

CEO/Administrator Dates 2013- Present
Present Position with the MDEG

Phone: 702 982 6678 Fax: 702 485 6332

Email address: Providence medical supply1@gmail.com

Date of Birth | Lagos, Nigeria
Place of Birth (City, County, State)

39 | | F
Age | Social Security Number | Sex

Brown | Black | 170 | 5'3"
Color of Eyes | Color of Hair | Weight | Height

Scars, tattoos or distinguishing marks and/or characteristics None

Are you a citizen of the United States? Yes ☑ No ☐

If alien, registration No

If naturalized, certificate No Date 02/22/2013

Place Las Vegas NV (If naturalized, document must be verified.)

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.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
11/2013 - Present	Providence Pharmacy 1729 E Charleston Blvd #F Las Vegas NV 89104	45 hours/week
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	verification of Medications & Medical Inventory supplies to patients	
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

I have ☐ I have not ☑ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☑ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☑ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☑ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked ☐ have ☐ to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: _____

b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☑ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☑ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☑ No ☐

If you answer No to questions 4, 5 or 6 pleas explanation.

.....

.....

.....

.....

.....

HOTOGRAPH

VITHIN LAST

'S HERE

Date of photograph 4/29/19

I, Modupe Irowbeji, 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 Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 4/10/19

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 DME (MDEG)
Nature of License

Providence Medical Supply 1729 E Charleston Blvd #F las vegas 89104
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Irorobeje	Modupe	Ajoke

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)
Braithwaite

Present Residence Address-Street or RFD	City	State/Zip
Kilkerran Ct	las vegas	NV 89141

Present Business Address	Dates	City	State/Zip
1729 E Charleston Blvd		las vegas	NV 89104

Occupation	Dates	Phone: Residence / Business
Pharmacist	2013 - Present	702-982-0078

Date of Birth	Place of Birth (City, County, State)
39	Lagos, Nigeria

Age	Social Security Number	Sex
		Female

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Brown	Black	Black	170	Average	5'3"

Scars, tattoos or distinguishing marks and/or characteristics None

Are you a citizen of the United States? Yes ☑ No ☐ If alien, registration No

If naturalized, certificate No [redacted] Date 2/22/2013

Place Las Vegas NV (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☑ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial MAI

MARITAL INFORMATION-Continued

A. **Current Marriage** 12/13/2007 (Date) las vegas, Clark, NV (City, County and State)

Spouse's full name (Maiden) Friday Ironbeji S.S. No

Date of Birth Place of Birth Ughelli, Nigeria

Resident address Kilkenan Ct las vegas NV 89141
Street City State Zip

Telephone: Residence Business 702 945 4202

Spouse's employer HealthCare Partners Occupation Nurse Practitioner

Address of employer 821 N Nellis Blvd Las vegas NV 89110
Street City State Zip

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
N/A				

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
Jeremiah Ironbeji		las vegas NV	Kilkenan Ct. las vegas 8914
Oghenegoma Ironbeji	11	11	11
Oghenemuno Ironbeji	11	11	11

B. Child Support Information:

Please mark the appropriate response:

☑ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial MMI

FAMILY INFORMATION-Continued

District attorney or public agency responsible for enforcing the child support order:

Name N/A

Address

Contact person

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Bankole Braithwaite			Deceased
Mother	Cecilia Thomas		Kilkenny Ct las vegas 89141	Retired
Father-in-Law	Michael Inowbeji		Akpodiete St. Ughelli North Delta State	Retired
Mother-in-Law	Grace Inowbeji		Akpodiete St. Ughelli North Delta State	Retired

D. Brothers and Sisters:

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
	Mobolaji Braithwaite		Miami Drive FL 33162	Customs Service
Spouse	Sylvia Braithwaite		Miami Drive FL 33162	House wife
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Maryland Convent Primary School		1985-1991	Yes ☑ No ☐
High School	Maryland Comprehensive Sec. School		1991-1997	Yes ☑ No ☐
College University	Florida Memorial University			Yes ☐ No ☐
Other	Miami Gardens FL 33054			Yes ☑ No ☐

Type of degree obtained, if any Pharm D 2007-2010

College or university where obtained Rosemann College of Health Sciences 11 Sunset way henderson NV 89014

Applicant's initial MMA

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☐ No ☑

Branch ..... Date of entry-active service .....

Date of separation ..... Type of discharge .....

Rating at separation ..... Serial 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.)

B. Have you registered for the draft? Yes ☐ No ☑

County ..... State ..... Date registered .....

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. 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 ☑ 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
			N/A		

B. 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 subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☑

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☑

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☑
If yes, when? ..... city, county and state .....

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☑
If yes when? ..... city, county and state .....

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☑
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date
		N/A		

Applicant's initial NMH

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?
Yes ☑ No ☐ (Other than divorces)
If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
Defendant- Bankruptcy	4/12/2010	10-16337-MKn	las Vegas NV	7/21/2010

J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
Yes ☐ No ☑ If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
N/A		

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
05/2003 - 08/2005	18068 SW 30th Ct	Miramar	Fl 33029
08/2005 - 08/2007	1020 NW 155 lane #305	Miami	Fl 33054
08/2007 - 12/2007	1100 N Center St #1825	Henderson	Nv 89015
01/2008 - 04/2011	5501 E Harmon Ave #5	Las Vegas	Nv 89122
05/2011 - 12/2017	3540 Tundra Swan St.	las vegas	Nv 8912
12/2017 - Present	Killaman Ct.	las vegas	Nv 89141

Applicant's 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	Name/Mailing Address of Employer/Business	Reason for Leaving
11/2013 - 04/19	Providence Pharmacy	Sold the business
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Pharmacy Manager	Medhya Inamdar
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
01/12 - 08/14	Walmart Pharmacy	Left to open my business
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Pharmacist	
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
10/2010 - 01/2012	CVS Pharmacy	Switched Companies
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	Pharmacist	Rhonda Lundgard
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
04/2011 - 10/2011	Advanced Care Pharmacy	Part time
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist	4161 S Eastern Avenue las vegas nv 89119	Jeny
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
05/2005 - 04/2006	Interactive Response Technology	
Title	**Description of Duties** 2989 N. Commerce Pkwy miramar fl	**Name of Supervisor**
Customer Service Rep.	Answering questions about phone services	
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
05/1998 - 04/2005		Full time Student
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**
Title	**Description of Duties**	**Name of Supervisor**

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

Applicant's initial MAT

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Nazalene Zebari	Home			Teton Ranch Ave	89052	7 years
Employer N/A	Business			N/A		
Name Felix Egbase	Home			Opal Cove Dr	89128	10 years
Employer Kindred Hosp	Business	5110 W Sahara		Las Vegas	89146	
Name Zeb Igelke	Home	5 Rainbow Blvd # 110			89145	10 years
Employer Alpha b Accounting	Business	222 S Rainbow Blvd # 110			89145	
Name Rose Stiffin	Home	NW 42nd Ave			FL 33054	16 years
Employer Florida Memorial Uni	Business	University Professor			78729	
Name Armelle Quedraogo	Home	3 Hunter Chase Dr # 424				15 years
Employer State of Texas	Business	Accounting				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person's depository? Yes ☐ No ☑
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A			

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☑
If yes, state type, where and years held

N/A

12. Have you ever applied for a city, county of state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☐ No ☑
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

N/A

Applicant's initial NAE

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☑

14. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☑

If yes to the above, state where, when and for what reason:

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☑

16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes ☐ No ☐

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer Yes ☐ No ☑

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes ☐ No ☑

Date of photograph 4/29/19

Applicant's initial MMF

STATE OF Nevada
ss.

COUNTY OF Clark

I, Modupe Ironbeji, 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.

Original Signature of Applicant

Subscribed and Sworn to before me this 1st day of May 2019

Mariam Jane Hasso
Notary Public

MARIAM JANE N. HASSO
Notary Public, State of Nevada
Appointment No. 15-2958-2
My Appt. Expires Jun 8, 2019

(seal)

Applicant's initial MAI

ADDITIONAL INFORMATION

N/A

Applicant's initial