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RECEIVED 7/14/2020

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy, Suite 206 – Reno, NV 89521 – (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 MP01163)

☐ 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: ActivStyle, Inc.

Physical Address: 3500 Lakeside Ct Ste 200 Reno, NV 89509-4829

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

Mailing Address: 220 W Germantown Pike Suite 250

City: Plymouth Meeting State: PA Zip Code: 19462

Telephone: 612-928-6826 Fax: 866-301-2167

E-mail: licensing@adapthealth.com Website: www.activstyle.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:00 to 4:30 Tue: 8:00 to 4:30 Wed: 8:00 to 4:30 Thu: 8:00 to 4:30

Fri: 8:00 to 4:30 Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Justin Garcia

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** Oral Nutrition Only
☐ 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: Justin Garcia Telephone: 612-928-6826

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:

1265720003-Medicare 1407173497-NV Medicaid

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:
☐ 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.

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

Diane Siegel
Print Name of Authorized Person

7/10/20
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP

List names of 4 largest partners and percentage of ownership:

Name: AdaptHealth LLC %: 100%

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: ActivStyle, Inc.

Mailing Address: 220 W Germantown Pike Ste 250

City Plymouth Meeting State: PA Zip Code: 19462

Telephone Number: 410-409-8741 Fax Number: 484-244-5488

Contact Person: Diane Siegel dsiegel@adapthealth.com

PARTNERSHIP

Include with the application for a partnership

Complete personal history record for each partner. 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*.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 07/01/2020

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 In State MDEG License

ActivStyle Inc. 3500 Lakeside Ct Ste 200 Reno NV 89509-4829
Name and Address of Establishment for Which License Is Requested

ActivStyle Inc.
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Parnes	Yehoshua	

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

Present Residence Address-Street or RFD	City	State/Zip
) Sean Court, Lakewood, N.		

Present Business Address	Dates	City	State/Zip
Germantown Pike, Suit	8/16/17 to present	Plymouth Meeting	PA 19462

Occupation	Dates	Phone Residence
President	8/16/17 to present	

Business 775-329-0799

Date of Birth	Place of Birth (City, County, State)
41	New York, Kings County, New York

Age	Social Security Number	Sex
		Male

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Green	Brown	Caucasian	180	Healthy	6'3"

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 Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage**

Spouse's full name (Maiden) Shaidy Carlbach Parnes (Date) S.S. N (City, County and State)

Date of Birth ..... Place of Birth .....

Resident address Sean Court, Lakewood, N
(Street) (City) (State) (Zip)

Telephone: Residence ..... Business .....

Spouse's employer Chemed Health Occupation APN

Address of employer 1771 Madison Ave, Lakewood NJ 08701
(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
Abraham Parn	Jerusalem, Israel,		Sean Court, Lakewood NJ 08701
Ahuba Parn	, Lakewood NJ		Sean Court Lakewood, NJ 08701
Eli Parnes	Lakewood NJ,		Sean Court, Lakewood NJ 08701
Jack Parnes	Lakewood NJ, 1		Sean Court, Lakewood NJ 08701
Shashona Parnes	Lakewood NJ,		Sean Court, Lakewood NJ 08701
Miriam Parnes	Lakewood NJ		Sean Court Lakewood NJ 08701

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 .....

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	David Parne		E h Street, Brooklyn, N	- Professor
Mother	Janet Parnes		th Street Brooklyn NY	- Lab Manager
Father-in-Law	Jonah Carlebach		Liberty Drive, Lakewood NJ	-Sales
Mother-in-Law	Rachel Carelbach		Liberty Drive, Lakewood, N.	Teacher

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
	Aaron Parnes		Brooklyn, NY	self-employed
Spouse	Nechama Weiss	unknown		N/A
	Eli Parnes		Baltimore MD	Teacher
Spouse	Bracha Leah Cohen	unknown		Teacher
	Shiffrah Garfunkle (Parnes)		Lakewood NJ	Speech Therapist
Spouse	Yitzchock Garfunkle	unknown		Student
	Avigauil Fischler		Baltimore, MD	Physical Therapist
Spouse	Shmuel Fischler	unknown		Social Worker

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Mirrer Yeshiva Elementary	1791 Ocean Parkway Brooklyn NY 11223	1982-1991	Yes ☒ No ☐
High School	Mirrer Yeshiva High School	1791 Ocean Parkway Brooklyn NY 11223	1991-1995	Yes ☒ No ☐
College University	Touro College	6th Avenue and West 23rd St, New York, NY 10010	1998-2000	Yes ☐ No ☒
	Talmudic Law School -BMG	Lakewood NJ 08701	1999-2003	
Other				Yes ☒ No ☐

Type of degree obtained, if any .....

College or university where obtained .....

Applicant's initial .....

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
2003-2006	51 Lopslsey Lane, Lakewood NJ		
2006-Present	Sean Court, Lakewood NJ		

Applicant's initial YP

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
11/2004	Caring Distribution 5722 18th Ave Brooklyn New York	Better Opportunity
Title	**Description of Duties**	**Name of Supervisor**
Sales Manager	Manage sales activities	John Carlebach

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1/2005 - Present	Ocean Home Health Supply LLC 1000 Airport Rd Lakewood NJ 08901	
Title	**Description of Duties**	**Name of Supervisor**
VP Operations/MFMT	Operations for Durable Medical Equipment Company	Luke McGee

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
April 2017-Present	AdaptHealth LLC (previously QMES LLC) 220 W Germantown Pike Suite 250 Plymouth Meeting PA 19462	
Title	**Description of Duties**	**Name of Supervisor**
President	Providing vision, strategic leadership for company	Luke McGee

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**

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 ....

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 Eli Friedman	Home	Chelsea Ct, Lakewood NJ		7:		10
Employer Plains Capital LLC	Business	428 Clifton Ave #100 Lakewood NJ 08701			732-886-6202	
Name Danny Kagan	Home	Sean Court, Lakewood N				5
Employer	Business					
Name Shmuel Peper	Home	Newbury Ct Lakewood NJ 08701				5
Employer	Business					
Name Moshe Shapira	Home	Spruce St Lakewood NJ 08701				10
Employer	Business					
Name Luke McGee	Home	1 Spruce Street, Philadelphia, PA 19102				
Employer Quadrant Capital Management	Business	Passaic Avenue Suite 301 Fairfield, NJ 07004				

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
Safe Deposit Box, Lakewood New Jersey - TD Bank			Michael Parnes

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.

Ocean Home Health Supply LLC New Jersey - 1000 Airport Rd, Suite 101 Lakewood NJ 08701

Medical Equipment Business, NJ Division of Taxation, see attached list

Applicant's initial .....

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 1-13-20

Applicant's initial

STATE OF New Jersey

ss.

COUNTY OF Ocean

I, Yehoshua Paines, 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 13 day of July 2020

Notary Public

(seal)

NECHAMA KRAKAUER
Commission # 50083228
Notary Public, State of New Jersey
My Commission Expires
May 24, 2023

Applicant's initial

ACORD

CERTIFICATE OF LIABILITY INSURANCE

5/17/2021

DATE (MM/DD/YYYY) 6/30/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	Lockton Companies 1185 Avenue of the Americas, Suite 2010 New York NY 10036 646-572-7300	CONTACT NAME:	
		PHONE (A/C, No, Ext):	FAX (A/C, No):
		E-MAIL ADDRESS:	
		INSURER(S) AFFORDING COVERAGE	NAIC #
		INSURER A : Benchmark Insurance Company	41394
INSURED 1422153	ActivStyle, Inc. 3500 Lakeside Ct, Ste 200 Reno NV 8959-4829	INSURER B : Hartford Fire Insurance Com an	19682
		INSURER C	
		INSURER D	
		INSURER E	
		INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** 16832304 **REVISION NUMBER:** XXXXXXX

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES LIMITS SHOWN MAY HAVE BEEN RED CED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY	N	N	D1019 G6279-1	5 17 2020	5/17/2021	EACH OCCURRENCE	$ $1,000 000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ $1 000 000
							MED EXP (Any one person)	$ $10,000
							PERSONAL & ADV INJURY	$ $1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ $3,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ $1,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY			NOT APPLICABLI			COMBINED SINGLE LIMIT (Ea accident)	$ XXXXXXX
	ANY AUTO						BODILY INJURY (Per person)	$ XXXXXXX
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$ XXXXXXX
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$ XXXXXXX
								$ XXXXXXX
A	X UMBRELLA LIAB X OCCUR	N	N	UM1019 6280-1	5 17 2020	5/17/2021	EACH OCCURRENCE	$ $10 000 000
	EXCESS LIAB CLAIMS MADE						AGGREGATE	$ $10 000 000
	DED RETENTION $							$ XXXXXXX
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			NOT APPLICABLE			PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N / A (Mandatory in NH)						E.L. EACH ACCIDENT	$ XXXXXXX
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ XXXXXXX
							E.L. DISEASE - POLICY LIMIT	$ XXXXXXX
A	Prof Liab	N	N	D1019 G6279-1	5 17 2020	5 17 2021	S1MM per occ S3MM agg	
B	Blanket BPP			39 UUN DF2446	5 17 2020	5 17 2021	Limit $58,939,860	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

16832304
National Supplier Clearinghouse
AG-495 Palmetto GBA
P.O. Box 100142
Columbia SC 29202-3142

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE Michael P Calabrese

AdaptHealth LLC Entities

Legal Name	President	Address			
AdaptHealth LLC	Yehoshua Parnes	220 W Germantown Pike Suite 250	Plymouth Meeting	PA	19462
ActivStyle, Inc	Yehoshua Parnes	1701 Broadway Street NE	Minneapolis	MN	55413
AdaptHealth - Missouri LLC	Yehoshua Parnes	5436 Bleaux Ave, Ste A	Springdale	AR	72762-0750
AdaptHealth Patient Care Solutions Inc.	Yehoshua Parnes	600 Lindbergh Drive	Moon Township	PA	15108-2777
Advocate Medical Services, Inc. dba ActivStyle	Yehoshua Parnes	5912 Breckenridge Parkway Suite G	Tampa	FL	33610
Aircare Home Respiratory LLC	Yehoshua Parnes	13311 Garden Grove Blvd, Ste D	Garden Grove	CA	92843-2202
All American Home Aid, Inc. dba ActivStyle	Yehoshua Parnes	169 W Springfield St Unit B	Boston	MA	02118-1403
American Ancillaries Inc	Yehoshua Parnes	4135 N Rancho Drive, Suite 110	Las Vegas	NV	89130-3494
Americoast Maryland LLC	Yehoshua Parnes	9321 Philadelphia Road, Suite K-L	Rosedale	MD	21237-4100
Associated Healthcare Systems, Inc.	Yehoshua Parnes	34 Riley Ave, Suite 3	Plattsburgh	NY	12901-1644
Bennett Medical Services	Yehoshua Parnes	2600 Mill Street, Suite 600	Reno	NV	89502-0105
Braden Partners, L.P.	Yehoshua Parnes	4882 McGrath St, Ste 220	Ventura	CA	93003-7721
Champlain Valley Brace & Limb LLC dba ActivStyle	Yehoshua Parnes	762 State Rte 3 Ste 15	Plattsburgh	NY	12901-7472
Choice Medical Healthcare LLC	Yehoshua Parnes	56 E Broadway, Ste 600	Salt Lake City	UT	84111-2211
Clearview Medical Incorporated	Yehoshua Parnes	2503 Gravel Drive	Fort Worth	TX	76118-6904
First Choice Home Medical Equipment, LLC	Yehoshua Parnes	259 Quigley Blvd, Suite 1	New Castle	DE	19720-4186
Florida Home Medical Supply Inc dba Colonial Medical Supplies	Yehoshua Parnes	614 E ALTAMONTE DR	ALTAMONTE SPRINGS	FL	32701-4803
Gould's Discount Medical LLC	Yehoshua Parnes	3901 Dutchman's Lane, Suite 100	Louisville	KY	40207-4726
Halprin, Inc.	Yehoshua Parnes	2375 State Rd 332, Suite 1000	Canandaigua	NY	14424-7509
Healthline Medical Equipment, LLC	Yehoshua Parnes	4709 Lydia Dr	Wichita Falls	TX	76308-4537
Home Medical Express Inc.	Yehoshua Parnes	621 IL Route 83, Ste 101	Bensenville	IL	60106-1325
Home MediService LLC	Yehoshua Parnes	540 S Union Ave	Havre de Grace	MD	21078-3410

Home Wellness, Inc. dba ActivStyle	Yehoshua Parnes	700 Route 130 N Suite 208	Cinnaminson	NJ	08077-3366
Hometown Home Health LLC	Yehoshua Parnes	65 Salem Church Road	Jasper	GA	30143-5804
MARY Medical Inc. dba ActivStyle	Yehoshua Parnes	4656 E Dakota Avenue Ste 104	Fresno	CA	93726-4727
Med Way Medical, Inc	Yehoshua Parnes	1837 South 4130 West, Units A&B	Salt Lake City	UT	84104-4826
Med-Equip, Inc	Yehoshua Parnes	701B Ashland Avenue, Ashland Center Two, Bay 6	Folcroft	PA	19032-2026
Medstar Surgical & Breathing Equipment, Inc.	Yehoshua Parnes	99 Powerhouse Rd, Suite 205	Roslyn Heights	NY	11577-2039
Ocean Home Health of PA Inc	Yehoshua Parnes	122 Mill Road, Suite A160	Phoenixville	PA	19460-1412
Ocean Home Health Supply LLC	Yehoshua Parnes	1000 Airport Road, Suite 101	Lakewood	NJ	08701-5960
Ogles Oxygen LLC	Yehoshua Parnes	1890 W Oak Pkwy, Ste A	Marietta	GA	30062-2278
Olean General Health Care Systems, LLC	Yehoshua Parnes	234 Homer Street	Olean	NY	14760-1132
Palmetto Oxygen LLC	Yehoshua Parnes	104 Corporate Blvd, Ste 402	West Columbia	SC	29169-4600
Roberts Home Medical LLC	Yehoshua Parnes	20465 Seneca Meadows Parkway	Germantown	MD	20876-7005
Royal HomeStar, LLC	Yehoshua Parnes	2710 Emrick Boulevard	Bethlehem	PA	18020-8012
Royal Medical Supply, Inc.	Yehoshua Parnes	1951 Old Cuthbert Road, Suite 413	Cherry Hill	NJ	08034-1411
Sleep Therapy LLC	Yehoshua Parnes	2157 Troop Drive, Suite 100	Sartell	MN	56377-4563
Sleepeasy Therapeutics, Inc.	Yehoshua Parnes	3003 32nd Ave S, Ste 7C	Fargo	ND	58103-6163
Sound Oxygen Service Inc	Yehoshua Parnes	8322 S 259th Street	Kent	WA	98030-7428
Total Respiratory LLC	Yehoshua Parnes	4211 Medical Parkway, Ste B	Austin	TX	78756-3309
TriCounty Medical Equipment and Supply, LLC	Yehoshua Parnes	122 Mill Road Suite A130	Phoenixville	PA	19460-1412
Verus Healthcare LLC	Yehoshua Parnes	1569 Mallory Lane, Building 100	Brentwood	TN	37027-2872

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

ActivStyle, Inc.

RENO, NEVADA

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

DMEPOS

Medical Supply Provider Services

FROM *July 1, 2020* THROUGH *February 6, 2023*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

adapthealth

July 10, 2020

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy Suite 206
Reno, NV 89521

RE: Change of Ownership
ActivStyle Inc.
NV Medical Device, Equipment & Gases Permit No. MP01163

To Whom It May Concern,

Please find enclosed NV Medical Device, Equipment & Gases application for a change of ownership for ActivStyle Inc. License Number MP01163.

There is no change to the entity name, ActivStyle Inc., tax identification number, or day to day operations. ActivStyle Inc. will continue to operate from its current location with current MDEG Administrator, Justin Garcia.

We are working to have the Personal History Record completed and submitted, however, due to the notification requirement by the NV BOP for a change of ownership we are submitting the application, payment and additional supporting documents now to meet the notification requirement.

I may be reached at 410-409-8741 or via e-mail at dsiegel@adapthealth.com with any questions or if additional information is needed.

Sincerely,

Diane Siegel
Licensing Manager

Enclosures

adapthealth

July 16, 2020

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy Suite 206
Reno, NV 89521

RE: Change of Ownership
ActivStyle Inc.
NV Medical Device, Equipment & Gases Permit No. MP01163

To Whom It May Concern,

The NV Medical Device, Equipment & Gases application for a change of ownership for ActivStyle Inc. License Number MP01163 was overnighted on 7/13/20 and confirmed delivered on 7/14/20.

Please find enclosed additional document, Personal History Record, for Yehoshua Parnes, President, ActivStyle Inc. for processing with the application.

I may be reached at 410-409-8741 or via e-mail at dsiegel@adapthealth.com with any questions or if additional information is needed.

Sincerely,

Diane Siegel
Licensing Manager

Enclosures

12B

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy, Suite 206 – Reno, NV 89521 – (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 MP00147)

☐ 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: Denham Orthotics & Fitness / DBA Evolve Prosthetics & Orthotics

Physical Address: 601 Whitney Ranch C-17 Henderson NV 89014

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

Mailing Address: S/A

City: Henderson State: NV Zip Code: 89014

Telephone: 702 898 6000 Fax: 702 898-6080

E-mail: prosynes@gmail.com Website: evolveprosthetics.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 to 5 Tue: 8 to 5 Wed: 8 to 5 Thu: 8 to 5

Fri: 8 to 5 Sat: ~~8~~ to ~~5~~ Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: David Kovach

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:

MEDICAID 1891751723 _____ _____

MEDICARE 4385780001 _____ _____

_____ _____ _____

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: DAVID KOVACH DO FACO
☐ 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.

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

David Kovach
Print Name of Authorized Person

6/29/20
Date

Board Use Only	Received:	Amount: 5000

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: NV

Parent Company if any: DENHAM ORTHOTICS & FITNESS

Corporation Name: EVOLVE PROSTHETICS & ORTHOTICS

Mailing Address: 601 Whitney Ranch C-17

City: Henderson State: Zip: NV Telephone:

Fax: Contact Person: DAVID KOVACH

702 898-4000 Fax - 702 898-4080

For any corporation non publicly traded, disclose the following:

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

a) DAVID KOVACH ; ROTHBURY AVE W, NV 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. 100 @ / 2500

3) What was the price paid per share? Undetermined

4) What date did the corporation actually receive the cash assets? Dec 10TH 1999

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.

DAVID KOVACH - PRES.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 6/29/20

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 MDEG LISCENSE
Nature of License

DENTHAM ORTHOTICS & PROSTHETICS / EVOLVE PROSTHETICS & ORTHOTICS
Name and Address of Establishment for Which License Is Requested

EVOLVE PROSTHETICS AND ORTHOTICS
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

KOVACH — DAVID — ANTHONY
Last Name — First Name — Middle Name

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

[redacted] ROTHBURY AVE — LV — NV — 89141
Present Residence Address-Street or RFD — City — State/Zip

601 WHITNEY RANCH DR C-17 — Dates 2012-August — HENDERSON — NV — 89014
Present Business Address — City — State/Zip

OWNER / PROSTHETIST — Dates 2004- August
Occupation

Phone
Residen[redacted]
Business 702 898-6000

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

44 — [redacted] — M
Age — Social Security Number or ITIN — Sex

BLUE — BROWN — TAN — 230 — STUD LIKE — 5'11"
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 DK

MARITAL INFORMATION-Continued

A. **Current Marriage** Aug 29th 1997 (Date) LV, NV CLARK (City, County and State)

Spouse's full name (Maiden) KIM PERFINSKI SS# or :

Date of Birth _____ Place of Birth LV, NV

Resident address 5863 ROTHBURY AVE (Street) LV (City) NV (State) 89141 (Zip)

Telephone: Residence _____ Business 702 498-4000

Spouse's employer LAB CORP Occupation PHLEBOTOMIST

Address of employer FLOAT (Street) LV (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

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
ANTHONY KOVACH		LV, NV	AUSTIN, TX
ETHAN KOVACH		LV, NV	LV, NV
AIDAN KOVACH		LV, NV	LV, NV

B. **Child Support Information:**

Please mark the appropriate response:

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

N/A

- 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 DK

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	Deceased			
Mother	Jackie Kovach		E. Monroe LV, NV 89110	N/A
Father-in-Law	Deceased			
Mother-in-Law	Pat Moss		Hurricane, Ut.	N/A

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
	Chris Kovach	/ /	LV, NV	Librarian
Spouse				
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Mt View Elem	LV, NV	83-85	(Yes) No
High School	Eldorado H.S.	LV, NV	84-93	(Yes) No
College University	UNLV	LV, NV	93-98	(Yes) No
Other				Yes No

Type of degree obtained, if any B.S. ATC

College or university where obtained UNLV

Applicant's initial DK

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_____

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
N/A				

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
	Rothbury Ave	LV, NV 89141	CLARK 2010-present
	Conyers St	LV, NV 89141	CLARK 2002-present
	9820 Virginia Ave	Livonia, MI	2000-02

Applicant's initial_____

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.

4-2004 | Denham Orthotics & Fitness | Still here
Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving

Prosthetist | Custom Fab & delivery of O&P | Self/Denham
Title | Description of Duties | Name of Supervisor

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving

02-04 | Michigan Ortho Services | Aziz Nasser/None
Title | Description of Duties | Name of Supervisor

Prosthetist/Resident | Fab & delivery of O&P

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving

9/-00 | Star/Novacare | School
Title | Description of Duties | Name of Supervisor

P.T. Tech/ATC | Laundry/Maintenance | Denham/Dave

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

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________________

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 DAN HOLSTEIN	Home	LV,	NV			10
Employer	Business					
Name JESSE BERG	Home	LV,	NV			25
Employer	Business					
Name GEOFF [illegible]	Home	LV,	NV			5
Employer	Business					
Name RICH FRAKES	Home	LV,	NV			20
Employer	Business					
Name TROY BACHILL	Home	LV,	NV			15
Employer	Business					

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_____

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 DK

STATE OF NV

ss.

COUNTY OF Clark

I, David Kovacich, 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 30th day of June, 2020

Notary Public

JUAN FLORES
Notary Public, State of Nevada
Appointment No. 19-6583-01
My Appt. Expires Dec 20, 2023

(seal)

Applicant's initial_____

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 4/29/20

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 ORTHOTICS & PROSTHETICS
Nature of MDEG

DENTHAM ORTHOTICS & FITNESS DBA EVOLVE PROSTHETICS & ORTHOTICS
Name and Address of Business for Which MDEG Administrator Is Requested

EVOLVE PROSTHETICS & ORTHOTICS
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

KOVACH — Last Name
DAVID — First Name
A — Middle Name

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

ROTHBURY AVE LV, NV 89141
Present Residence Address-Street or RFD — City — State/Zip

601 Whitney Ranch — Dates C-17 2012-> present — Henderson, NV 89014
Present Business Address — City — State/Zip

Rothbury Owner — Dates 2019 → present
Present Position with the MDEG

Phone: 702 898 6000 — Fax: 702 898 6080

Email address: prosynes@gmail.com

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

44 — Age
Social Security Number or ITIN
M — Sex

Blue — Color of Eyes
Brown — Color of Hair
230 — Weight
6'5" — 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
April of Present	Denham Orthotics	32,240
Title	**Description of Duties**	**Name of Supervisor**
Prosthetist	Seeing Patients, Evaluating O&P needs	Self / Dave Denham
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 "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: _____

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.

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ATTACH PHOTOGRAPH

TAKEN WITHIN LAST

30 DAYS HERE

Date of photograph_____

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: _____

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 provid

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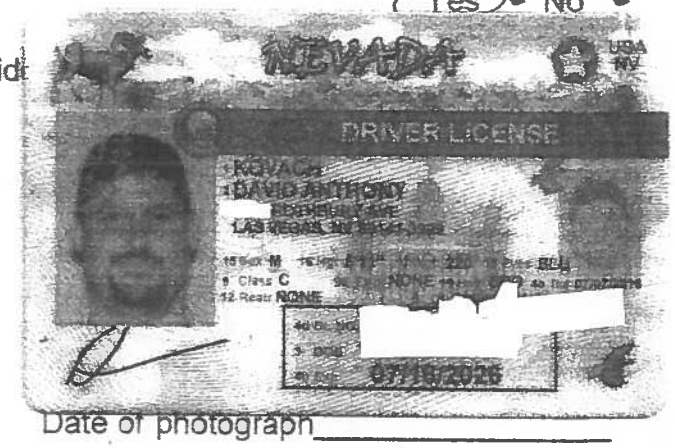
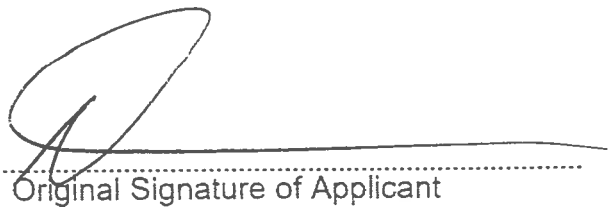


Date of photograph_____

I, David Kovacich, 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

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, Barbara K. Cegavske, the duly qualified and elected Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporations sole, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada Revised Statutes which are either presently in a status of good standing or were in good standing for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **DENHAM ORTHOTICS AND FITNESS**, as a DOMESTIC CORPORATION (78) duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since 12 10 1999, and is in good standing in this state.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on 06 29 2020.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Certificate Number: B20200629891259
You may verify this certificate online at http://www.nvsos.gov

12C

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy, Suite 206 – Reno, NV 89521 – (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 N/A)

☐ 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: First Care Medical Supply LLC

Physical Address: 3655 S Durango dr unit 10 Las Vegas NV 89147

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

Mailing Address: 3655 S. Durango dr unit 10

City: Las Vegas State: NV Zip Code: 89147

Telephone: (702)6842415 Fax: _____

E-mail: Supply@Firstcaremedical.org Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9:00 AM to 5:00 PM Tue: 9:00 AM to 5:00 PM Wed: 9:00 AM to 5:00 PM Thu: 9:00 AM to 5:00 PM

Fri: 9:00 AM to 5:00 PM Sat: closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Knarik Avagyan

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: Knarik Avagyan Telephone: (702) 684 24 15

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:

Medicaid		
Medicare		

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:
☐ 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.

N/A

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: N/A

Parent Company if any: _____

Corporation Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

License Contact Person: _____

Ownership Information – Complete Section 1 or 2

Do not use N/A in this section – Section 1 or 2 must be completed.

Section 1: List the corporations four largest shareholders:
(Name and percentage of ownership)

1. _____ %: _____

2. _____ %: _____

3. _____ %: _____

4. _____ %: _____

Section 2: If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: _____

Registration number issued: _____

Stock Exchange: _____

Include with the application for a publicly traded corporation

List of officers and directors.

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.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

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

Knarik Avagyan
Print Name of Authorized Person

5-17-2020
Date

Board Use Only	Received:_____	Amount: _____

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Corporation Name: First Care Medical Supply LLC

Mailing Address: 3655 S Durango dr unit 10

City: Las Vegas State: Zip: NV Telephone: (702) 684-2415

Fax: _____ Contact Person: Knarik Avagyan

For any corporation non publicly traded, disclose the following:

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

a) Knarik Avagyan ... Rain Lily ct Las Vegas NV 8911,
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. _____

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.

Knarik Avagyan

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, Barbara K. Cegavske, the duly qualified and elected Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporations sole, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada Revised Statutes which are either presently in a status of good standing or were in good standing for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **First Care Medical Supply LLC** , as a DOMESTIC LIMITED-LIABILITY COMPANY (86) duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since 12/17/2019, and is in good standing in this state.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on 04/17/2020.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Certificate Number: B20200417733620
You may verify this certificate online at http://www.nvsos.gov

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

1648

ENTITY NUMBER

FIRST CARE MEDICAL SUPPLY LLC

NAME OF CORPORATION

E3592762019-7

FOR THE FILING PERIOD OF DEC, 2019 TO DEC, 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.)

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.

ABOVE SPACE IS FOR OFFICE USE ONLY

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)		
KNARIK AVAGYAN	PRESIDENT (OR EQUIVALENT OF)		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
RAIN LILY CT	LAS VEGAS	NV	89117

NAME	TITLE(S)		
KNARIK AVAGYAN	SECRETARY (OR EQUIVALENT OF)		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
RAIN LILY CT	LAS VEGAS	NV	89117

NAME	TITLE(S)		
KNARIK AVAGYAN	TREASURER (OR EQUIVALENT OF)		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
RAIN LILY CT	LAS VEGAS	NV	89117

NAME	TITLE(S)		
KNARIK AVAGYAN	DIRECTOR		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
RAIN LILY CT	LAS VEGAS	NV	89117

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 _____

Signature of Officer or Other Authorized Signature

Title MEMBER

Date 05/19/2020

Reset

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

HEADQUARTERS:
PO Box 3867
Bellevue, WA 98009
P: 800.562.8095
F: 425.453.8696
WWW.goGUS.COM

GRIFFIN
UNDERWRITING SERVICES
In CA, DBA: Griffin Insurance Services, CA License #0G66558

April 30, 2020

The McPherson Group
5515 Camino Al Norte Ste 106
North Las Vegas, NV 89031

Attn: Morris McPherson

Re: First Care Medical Supply LLC
Effective Date: 4/28/2020

We are pleased to confirm coverage for you with the following confirmation of binding. This confirmation is offered in accordance with your instructions and in reliance upon the statements made in your application. Please review carefully. Thank you for your business, the policy should follow within 30 days.

Best Regards,

Matthew Griffin
Commercial Underwriting Assistant
Griffin Underwriting Services
matthew@gogus.com

Reference #: 20235001B
Agent Fax #: (702) 649-4977

HEADQUARTERS:
PO Box 3867
Bellevue, WA 98009
P: 800.562.8095
F: 425.453.8696
WWW.goGUS.COM

GRIFFIN
UNDERWRITING SERVICES
In CA, DBA: Griffin Insurance Services, CA License #0G66558

Acct. Exec wdear

INVOICE

Invoice Number: 676004
Invoice Date: 04/30/20
Page 1

Bill To: ASI41293

The McPherson Group
5515 Camino Al Norte Ste 106
North Las Vegas, NV 89031

Insured: First Care Medical Supply LLC
Submission Number: 20235001
Policy Number: MP0046003012548
Effective Dates: 04/28/20 to 4/28/21
Insurance Company: Mesa Underwriters Specialty Insurance C
Agent Code: ASI41293

Type of Transaction	Line of Business	Company ID	Amount	Comm($)	Net Due
Premium - New Business	PACKAGE POLICY	RM0532	$1,250.00	$75.00	$1,175.00
Policy Fee	PACKAGE POLICY	01	$185.00	$0.00	$185.00
Surplus Lines Tax	PACKAGE POLICY	T0011	$50.23	$0.00	$50.23
Stamping Office Fee	PACKAGE POLICY	T0021	$5.74	$0.00	$5.74

TOTALS:	Amount Invoiced:	Comm %	Commission	Invoice Amount Due
	$ 1,490.97	6.00	$ 75.00	**$ 1,415.97**

Invoice Payment Due On: 5/30/20

Note:

CONFIRMATION OF BINDING

THE TERMS AND CONDITIONS OF THIS CONFIRMATION OF INSURANCE MAY NOT COMPLY WITH THE SPECIFICATIONS SUBMITTED FOR CONSIDERATION. PLEASE READ THIS CONFIRMATION CAREFULLY AND COMPARE IT WITH ANY QUOTE AND SUBMISSION DOCUMENTS AND REVIEW THE POLICY FORMS FOR THE ACTUAL COVERAGES PROVIDED. THIS CONFIRMATION IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) OR CERTIFICATE(S) IN CURRENT USE BY THE INSURER.

In accordance with your instructions, and in reliance upon the statements made by the retail producer in the insured's application/submission, we have bound insurance at your request as follows:

Date Issued: Apr 30, 2020
Submission #: 20235001B

Is this a Renewal? N

Producer: ASI41293
The McPherson Group
5515 Camino Al Norte Ste 106
North Las Vegas, NV 89031

Insured:
First Care Medical Supply LLC
3655 S Durango Dr Ste 10
Las Vegas, NV 89147

Location of Risk: 3655 S Durango Dr Ste 10, Las Vegas, NV 89147

Insurer: Mesa Underwriters Specialty Insurance Co.

Assigned Policy or Certificate Number: **MP0046003012548**

"This insurance contract is issued pursuant to the Nevada insurance laws by an insurer neither licensed by nor under the supervision of the Division of Insurance of the Department of Business and Industry of the State of Nevada. If the insurer is found insolvent, a claim under this contract is not covered by the Nevada Insurance Guaranty Association Act." Cochrane Griffin & Co Inc, License #609660

Effective Period: 4/28/2020 to 4/28/2021 **Term:** 365 days

12:01 A.M. STANDARD TIME AT THE LOCATION ADDRESS OF THE NAMED INSURED. THIS CONFIRMATION WILL BE TERMINATED AND SUPERSEDED UPON DELIVERY OF THE FORMAL POLICY(IES) ISSUED TO REPLACE IT.

Coverage: PACKAGE POLICY

Limits:	$2,000,000	General Aggregate
	$2,000,000	Products/Comp Ops Aggregate
	$1,000,000	Personal & Advertising Injury
	$1,000,000	Each Occurrence
	$100,000	Damage to Premises Rented to You (Any One Premises)
	$5,000	Medical Exp (Any One Person)
	N/A	Additional Insured perform CG2011 (x1)
	Property Cause of Loss: Special Form Excluding Theft	
	$40,000	Business Personal Property-90% Coinsurance, RC
Deductible:	$500	General Liability
	$1,000	Property
Exposures:	$52,000 Sales	(15314) Medical, Hospital and Surgical Supply Stores
	Each-1	(11111) Additional Insured perform CG2011

Terms/Conditions: **(a) 25% minimum earned premium at inception.**

(b) Endorsements / Notable Exclusions:

Common
IL 00 17 11 98 COMMON POLICY CONDITIONS
ILN 001 09 03 FRAUD STATEMENT
MUS 01 01 10001 0817 POLICY JACKET
MUS 01 01 10002 1116 COMMON POLICY DECLARATION
MUS 01 01 10003 1013 SCHEDULE OF FORMS & ENDORSEMENTS
MUS 01 01 10007 1013 MINIMUM EARNED PREMIUM ENDORSEMENT
MUS 01 01 10015 1013 NV NV SERVICE OF SUIT
MUS 01 01 10043 1013 PRIVACY NOTICE
MUS 01 01 TRIA 0115 TRIA COVERAGE ACCEPT-REJCT FORM

General Liability
CG 00 01 04 13 COMMERCIAL GENERAL LIABILITY COVG FORM
CG 20 11 04 13 AI - MANAGERS OR LESSORS OF PREMISES

CG 21 16 04 13 EXCL - DESIGNATED PROFESSIONAL SERVICES (Any and All Professional Exposures)
CG 21 32 05 09 EXCL - COMMUNICABLE DISEASE
CG 21 47 12 07 EMPLOYMENT-RELATED PRACTICES EXCLUSION
CG 21 55 09 99 EXCL - TOTAL POLLUTION EXCLUSION WITH A HOSTILE FIRE EXCEPTION
CG 21 67 12 04 EXCL - FUNGI OR BACTERIA
CG 21 73 01 15 EXCL OF CERTIFIED ACTS OF TERRORISM
CG 21 96 03 05 EXCL - SILICA OR SILICA-RELATED DUST
CG 24 26 04 13 AMENDMENT OF INSURED CONTRACT DEFINITION
IL 00 21 09 08 NUCLEAR ENERGY LIABILITY EXCL ENDT
MUS 01 01 20001 0417 GENERAL LIABILITY COVERAGE PART DECLARATIONS
MUS 01 01 20004 0916 LIABILITY DEDUCTIBLE
MUS 01 01 20023 1013 SPECIAL CONDITIONS - SUBCONTRACTORS
MUS 01 01 20058 0816 EXCL - LEAD CONTAMINATION
MUS 01 01 20063 0919 EXCL - PUNITIVE DAMAGES
MUS 01 01 20080 0816 EXCL - EARTH MOVEMENT
MUS 01 01 20082 0816 EXCL - ASBESTOS
MUS 01 01 20084 0816 NON-STACKING OF LIMITS ENDORSEMENT
MUS 01 01 20094 0718 AMENDMENT OF CONDITIONS - PREMIUM AUDIT
MUS 01 01 20112 1013 EXCL - OCCUPATIONAL DISEASE
MUS 01 01 20139 0617 EXCL - INFRINGEMENT OF INTELLECTUAL PROPERTY

Property
CP 00 10 10 12 BUILDING & PERSONAL PROPERTY COVG FORM
CP 00 90 07 88 COMMERCIAL PROPERTY CONDITIONS
CP 01 40 07 06 EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA
CP 10 30 10 12 CAUSES OF LOSS - SPECIAL FORM
CP 10 33 10 12 EXCL - THEFT
IL 01 10 09 07 NV CHANGES - CONCEALMENT, MISREPRESENT OR FRAUD
IL 09 53 01 15 EXCL - CERTIFIED ACTS OF TERRORISM
MUS 01 01 30001 0417 PROPERTY COVERAGE PART DECLARATIONS
MUS 01 01 30016 1013 EXCL - ABSOLUTE ASBESTOS
MUS 01 01 30021 1013 LEAD EXCLUSION
MUS 01 01 30022 1013 POLLUTION EXCLUSION
MUS 01 01 30023 1013 SINKHOLE EXCLUSION
MUS 01 01 30024 1013 ACTUAL CASH VALUE

(c) Binding Requirements / Subject To:

25% MINIMUM EARNED PREMIUM APPLIES IN THE EVENT OF CANCELLATION

SEE CHECKLIST FOR BINDING

(d) All other terms and conditions apply per policy forms.

Premium:		$1,250.00	*- Minimum Premium & Deposit Only -*
Fees:	Policy Fee	$185.00	
Taxes:		$55.97	**Total Due: $1,490.97**

TRIA: Terrorism Coverage: plus in taxes: **REJECTED**

Cancellation: This Confirmation is subject to the cancellation provisions as found in the policy(ies) or certificate(s) currently in use by the insurer. The Insurance effected under this confirmation can be cancelled by the insurer by mailing, to the first named insured at the address stated on the confirmation, written notice stating when such cancellation shall become effective. The Insurance effected under this confirmation may be cancelled by the named insured by giving written notice to Griffin Underwriting Services, stating when thereafter the cancellation shall become effective. Cancellation can not be effected prior to the post mark date of the written notice. In the event of cancellation by the insured, the earned premium would be subject to the minimum premium if applicable. **THE INSURANCE UNDER THIS CONFIRMATION CAN NOT BE CANCELLED FLAT;** earned premium and any applicable fees and taxes must be paid for the time that insurance has been in force.

THIS CONFIRMATION OF INSURANCE IS ISSUED BASED UPON THE INSURER'S AGREEMENT TO BIND AND IS ISSUED BY THE UNDERSIGNED WITHOUT ANY LIABILITY WHATSOEVER AS AN INSURER.

AUTHORIZED REPRESENTATIVE, GRIFFIN UNDERWRITING SERVICES

INSURED: First Care Medical Supply LLC

DATE ISSUED: Apr 30, 2020 **SUBMISSION #:** 20235001

Date 5-17-2020

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 MDEG
Nature of License

First Care Medical Supply LLC 3655 S Durango dr. unit 10 Las Vegas NV 89
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It is Now Operated

1. PERSONAL INFORMATION:

Avagyan (Last Name) | Knarik (First Name) | none (Middle Name)

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

Rain Lily Ct (Present Residence Address-Street or RFD) | Las Vegas (City) | NV 89117 (State/Zip)

3655 S Durango dr unit 10 (Present Business Address) | Dates | Las Vegas (City) | NV 89147 (State/Zip)

Occupation | Dates | Phone: Residenc

Armenia, Yerevan (Place of Birth (City, County, State)) | Business (702) 684 2415 (Date of Birth)

47 (Age) | Social Secu | F (Sex)

brown (Color of Eyes) | brown (Color of Hair) | 160 (Weight) | Build | 5'7" (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.)

2. MARITAL INFORMATION:

Single → Married → Separated → Divorced ✓ Widowed → Engaged →

Applicant's initial A.K.

A. **Current Marriage** N/A
Date City, County and State

Spouse's full name (Maiden)_____ SS# or ITIN_____

Date of Birth_____ Place of Birth_____

Resident address_____
Street City State Zip

Telephone: Residence_____ Business .....

Spouse's employer_____ Occupation_____

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
Arthur Gaplanian		04-29-02	divorced.	Las Vegas, Clark, NV

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

Name	Street	City	State	Zip	Telephone
Arthur Gaplanian,		Moorecroft St Las Vegas	NV	89147	

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
Erik Khachatryan		Armenia	c/ Rain Lily of Las Vegas, NV 8911.
Gabriel Gaplanian		Los Angeles	Rain Lily of Las Vegas NV 89117

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 A.K.

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	Samvel Avagyan	deceased	Armenia	
Mother	Marta Avagyan	deceased	Armenia	
Father-in-Law	Gabriel Gaplanian	deceased	Los Angeles	
Mother-in-Law	Lusik Nalbandian	deceased	Las Vegas	

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
	Agasi Avagyan		Armenia	
Spouse	Anahit Zohrabyan		Armenia	
Spouse				
Spouse				
Spouse				

4. **EDUCATION:**

	Name of School	Location	Dates Attended	Graduate
Grammar School	#172	Armenia	1980-1985	Yes X No
High School	#172	Armenia	1985-1990	Yes X No
College University	Yerevan State University			Yes X No
Other				Yes No

Type of degree obtained, if any Masters degree organic chemistry

College or university where obtained

Applicant's initial A.K.

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

Branch N/A 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 N/A 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 A.K.

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
N/A				

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
2012 - Present	Rain Lily Ct	Las Vegas	NV 89117
2009 - 2012	9125 W Reno Ave apt 2106	Las Vegas	NV 89118
2008 - 2009	9516 Trattoria st	Las Vegas	NV 89178
2007 - 2008	9947 Antelope Canyon	Las Vegas	NV 89147
2002 - 2007	4417 Cinderella Ct	Las Vegas	NV 89102
2001 - 2002	7E E Twain Ave apt D	Las Vegas	NV 89109
1999 - 2001	Armenia, Yerevan		

Applicant's initial A. K.

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
1-1-20-Present	First Care Medical Supply LLC 3655 S Durango dr. unit 10	
Title	**Description of Duties**	**Name of Supervisor**
member	administrator	Knarik

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
6-6-19	AAA Healthcare Products Inc 18529 Rosco Blvd, Northrid	
Title	**Description of Duties**	**Name of Supervisor**
clerk	Responsible for patients orders	Anahit

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2014-2018	Flamingo Apparel 3950 Las Vegas Blvd.	
Title	**Description of Duties**	**Name of Supervisor**
salesperson	selling Products	Yori

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4-1-2014	Sunset Center Pharmacy and Supply 5137 1/2 Sunset Blvd	
Title	**Description of Duties**	**Name of Supervisor**
clerk	Responsible for patients orders	Vardan

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2015-2016	E & G Express LLC 3824 S Jones Blvd. suit K	
Title	**Description of Duties**	**Name of Supervisor**
manager	selling time talles and cargo	Knarik

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2006-2012	Charisma 3000 Paradise Rd Las Vegas 89109	
Title	**Description of Duties**	**Name of Supervisor**
salesperson	selling apparel	Marino

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2005-2006	Regis Signature 3000 Paradise Rd.	
Title	**Description of Duties**	**Name of Supervisor**
Recepticnist	answering and directing calls	Tamara

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2003-2005	Regis Signature 3770 S Las Vegas Blvd.	
Title	**Description of Duties**	**Name of Supervisor**
Receptionist	answering and directing calls	Amy

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

Applicant's initial A.K.

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 Stella	Home	Masked Duck	Las Vegas	NV 89117		19 years
Employer Pharmacist	Business	Albertsons				
Name Karine	Home	Harbor Heights	Las Vegas	NV 89117		18 years
Employer owner	Business	Bridal Elegance and Tuxedos				
Name Sousanna	Home	Las Vegas	NV 89117			10 years
Employer manager	Business	MGM Resorts Int.				
Name Naira	Home	Glendale	CA			40 years
Employer manager	Business	IV Hospice INC				
Name Amy	Home	Las Vegas	NV 89147			10 years
Employer Lead Esthetician	Business	Delano Hotel				

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 A.K.

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 5-21-2020

Applicant's initial A.K.

ss.

COUNTY OF Clark

I, Knarik Avagyan, 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 21st day of May, 2020 by Knarik Avagyan xxx

Notary Public

(seal)

J. LANCE DOMINGCIL
Notary Public - State of Nevada
County of Clark
APPT. NO. 12-8435-1
My App. Expires Aug. 6, 2020

Applicant's initial A.K.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 5-17-2020

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 Medical Equipment and Supply
Nature of MDEG

First Care Medical Supply LLC 3655 S Durango dr unit 10 Las Vegas NV 89147
Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Avagyan — Last Name
Knarik — First Name
Middle Name

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

Rain Lily Ct — Present Residence Address-Street or RFD
Las Vegas — City
NV 89117 — State/Zip

3655 S Durango dr. unit 10 — Present Business Address
Dates
Las Vegas — City
NV 89117 — State/Zip

N/A — Present Position with the MDEG
Dates

Pho _ _ Fax:

Email address: supply@Firstcaremedical

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

47 — Age
Social Security Number or ITIN
F — Sex

Brown — Color of Eyes
Brown — Color of Hair
160 — Weight
5'7" — 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.)

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
1-1-2020	First Care Medical Supply LLC 3655 S. Durango	
Title	**Description of Duties**	**Name of Supervisor**
member		Knarik

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
6-6-19	AAA Healthcare Products Inc. 18529 Roseo Blvd. Northridg	520
Title	**Description of Duties**	**Name of Supervisor**
clerk	Responsible for patients orders	Anahit

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
4-1-2014	Sunset Center Pharmacy and Supply 5137 ½ Sunset Blvd	1040
Title	**Description of Duties**	**Name of Supervisor**
clerk	Responsible for patients orders.	Vardan

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 <u>and</u> 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 please provide a writ

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.....

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.....

.....

Date of photograph 5-21-2020

I, Knarik Avagyan, 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, certificat**ion, 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

12D

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy, Suite 206 – Reno, NV 89521 – (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: Nevada Limb & Brace, LLC

Physical Address: 1505 Wigwam Pkwy, Suite 141 Henderson, NV 89074

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

Mailing Address: 1505 Wigwam Pkwy Suite 141

City: Henderson State: Nevada Zip Code: 89074

Telephone: (702) 899-1700 Fax: (702) 899-1813

E-mail: vanisg@NVLAB1.com Website: N/A

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:00 to 5:00 Tue: 8:00 to 5:00 Wed: 8:00 to 5:00 Thu: 8:00 to 5:00

Fri: 8:00 to 5:00 Sat: N-A to Sun: N-A to Holidays: N-A to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Vanis Ingrid Gardea

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: Roger Beihl Telephone: (702) 672-7971

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:

N - A		

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:
☐ 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.

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.

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

Vanis Ingrid Gardea
Print Name of Authorized Person

05-13-2020
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: Vanis Ingrid Gardea

Business Name: Nevada Limb & Brace, LLC

Current Business Address: 1505 Wigwam Pkwy Suite 141

City: Henderson State: NV Zip: 89074

Telephone: (702) 899-1700 Fax: (702) 899-1813

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*.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 05-13-2020

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 Medical Device Equipment and Gases (MDEG)
Nature of License

Nevada Limb & Brace, LLC 1505 Wigwam Pkwy Suite 141
Name and Address of Establishment for Which License Is Requested

Henderson, NV 89074
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Gardea — Last Name
Vanis — First Name
Ingrid — Middle Name
Guzman — Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

[redacted] Coastal Fog Ave. — Present Residence Address-Street or RFD
Las Vegas — City
NV 89183 — State/Zip

1505 Wigwam Pkwy — Present Business Address
Dates
Henderson — City
NV 89074 — State/Zip

Accountant-Owner — Occupation
Dates 2006 to Current

Phone:
Residence [redacted]
Business (702) 899-1700

San Salvador, El Salvador — Date of Birth / Place of Birth (City, County, State)

44 — Age
Social Security Number or ITIN
Female — Sex

Brown — Color of Eyes
Brown — Color of Hair
Medium — Complexion
135 lbs. — Weight
Build
5'2 — Height

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

Are you a citizen of the United States? (Yes) No — If alien, registration No N-A

If naturalized, certificate No ____ Date ____

Place Los Angeles, California, U.S.A (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single — (Married) — Separated — Divorced — Widowed — Engaged

Applicant's initial V.I.G

MARITAL INFORMATION-Continued

A. **Current Marriage** April 2nd, 2005 San Pedro, Los Angeles, CA
(Date) (City, County and State)

Spouse's full name (Maiden) Ruben Anthony Gardea SS# or ITIN _____

Date of Birth _____ Place of Birth Torrance, California, U.S.A

Resident addres _____ Coastal Fog Ave. Las Vegas, NV _____
(Street) (City) (State) (Zip)

Telephone: Residence _____ Business (702) 899-1700

Spouse's employer Trinity Orthopedic, LLC Occupation Pand O Technician - Owner

Address of employer 61 N. Pecos Rd Suite 105 Las Vegas, NV 89101
(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
Gabriel Ruben Gardea			
Jacy Anthony Gardea			
			Coastal Fog Ave. Las Vegas, 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 V. I. G.

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	Raul Mendoza		Flintlock Dr. Louisville, KY	Retired
Mother	Edith Guzman		Flintlock Dr. Louisville, KY	Hospital Maintenance
Father-in-Law	Jeannie Martin		El Cerro Dr. Buena Park, CA	Retired
Mother-in-Law	Lucio Gardea		3rd St. Long Beach, CA	Deseased

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	Claudia Rodriguez		Via Della Cavallara	Monteviale VI, Italy - Homemaker
Spouse	Juan Rodriguez		Via Della Cavallara Monteviale, VI Italy	U.S. Army
Spouse	Heidy Gastelum		Windemere Dr. Louisville, KY	Homemaker
Spouse	Concepcion Gastelum		Windemere Dr. Louisville, KY	Manager

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Limerick Ave. Elementary	Canoga Park, CA	1983 - 1988	(Yes) No
High School	John Freemont High	Los Angeles, CA	1991 - 1995	(Yes) No
College University	Cal State University Dominguez Hills	Carson, CA	2003 - 2006	(Yes) No
Other				Yes (No)

Type of degree obtained, if any Bachelor's Degree in Accounting

College or university where obtained California State University, Dominguez Hills

Applicant's initial V. I. G.

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes → (No) →

Branch N-A 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 N-A 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. Possible

Name	Relationship	Charge	Location	Date
Please refer to page 10.				

Applicant's initial V. I. G.

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
N-A				

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
Aug 2019- Current	10220 Coastal Fog Ave.	Las Vegas,	NV 89183
Dec. 2013 - Aug. 2019	10220 Crepe Myrtle CT.	Las Vegas,	NV 89183
Aug 2003- Aug 2013	2239 Gale Ave.	Long Beach,	CA 90810
Dec 1995- Aug 2003	8601 State St. apt #4	South Gate,	CA 90280

Applicant's initial V. L. G.

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
July 2019-Current | Nevada Limb & Brace, LLC 1505 Wigwam Pkwy Suite 141 Henderson, NV 89074 | Started my Company
Title | Description of Duties | Name of Supervisor
Administrator-Controller | Self

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
June 2019-April 2020 | Reno Oil of America - 5425 S. Valley View Blvd. Las Vegas, NV 89118 | Better Opportunity
Title | Description of Duties | Name of Supervisor
Accounting Manager | Sophia Del Pozo

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
May 2019-June 2019 | Red Moon, LLC 101 Convention Center Dr. 7th Floor. Las Vegas, NV 89109 | Entity Closed
Title | Description of Duties | Name of Supervisor
Assistant Controller | Melissa Lambson

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
Sept. 2017-May 2019 | M & K Enterprises, LLC 1950 East Maule Las Vegas, NV 89119 | Better opportunity
Title | Description of Duties | Name of Supervisor
Accounting Manager | Jennifer Turner

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
April 2017-Sept. 2017 | Blue Diamond Machinery 2880 N. Nellis Blvd. Las Vegas, NV 89115 | Relocated
Title | Description of Duties | Name of Supervisor
Bookkeeper | Scott Paulo

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
April 2016-April 2017 | Cannon Nevada, LLC 6671 S. Las Vegas Blvd. Suite 210, Las Vegas, NV 89119 | Entity closed
Title | Description of Duties | Name of Supervisor
Bookkeeper | Scott Paulo

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
Sept. 2013-April 2016 | Ampro Orthotics & Prosthetics 6877 S. Eastern Ave. Las Vegas, NV 89119 | Moved to Nevada
Title | Description of Duties | Name of Supervisor
Accountant | Karen Jarvis

Month and Year | Name/Mailing Address of Employer/Business | Reason for Leaving
Sept 2012-July 2013 | Local Financial 1150 N. Magnolia Ave. Anaheim, CA 92801 |
Title | Description of Duties | Name of Supervisor
Assistant Controller | Luz Hooper

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

Applicant's initial V.I.G.

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 Maria Ponce	Hom	Cod Circle		Huntington Beach, CA	(714) 270-3135	18 years
Employer EBA & M	Business	18002 Cowan		Irvine, CA 92614		
Name Monica Rojas	Hon	Park Ave		Pasadena, CA 91030		
Employer Donlee Farms	Business	200 E. Beach Ave.		Inglewood, CA 90302		-30 years
Name Addy Trivino	Hom	W.		Los Angeles, CA 90006		
Employer L.A County	Business	14340 Sylvan St.		Los Angeles, CA 91401		- 25 years
Name Blanca Schreiner	Home	Cambridge Ave.		Castaic, CA 91384		
Employer Homemaker	Business	24 years.				
Name Roxanna Andino	Hom	S. Alta Vista Ave.		Monrovia, CA 91016		
Employer Kaiser	Business	3280 E. Foothill Blvd.		Pasadena, CA 91107		-30 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
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 V.I.G.

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) —

N-A

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

N-A

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

N-A

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)

N-A

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)

N-A

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) —

N-A

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) —

N-A

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)

N-A

Date of photograph 05-12-2020

Applicant's initial V.I.G.

STATE OF Nevada

ss.

COUNTY OF Clark

I, Vanis Ingrid Gardea, 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.

Vanis Ingrid Gardea
Original Signature of Applicant

Subscribed and Sworn to before me this 12th day of May, 2020
by Vanis Ingrid Gardea.

K. M. W.
Notary Public

KEITH M. WILSON
Notary Public - State of Nevada
(seal) County of Clark
APPT. NO. 12-8836-1
My App. Expires Sept. 18, 2020

Applicant's initial V. I. G.

From pg. 6

ADDITIONAL INFORMATION - Entity Closed

May 2010 - Sept 2012 Active Storage Inc. 2295 Jefferson St. Torrance, CA 90501 Accounting Manager - Jane Wike, CPA

Aug. 2006 - May 2010 International Cable & Connectors - Charles Brian, 2100 E. Valencia Dr. Ste D. Fullerton, CA 92831 CPA - Completed Degree

April 2005 - Aug. 2006 SJS Enterprises, Inc. 9030 Somerset Blvd. Bellflower, CA 90706 - Accounts Payable and Receivable Manager - Growth Opportunity

Oct. 2000 - Nov. 2004 Human Designs, Prosthetic and orthotics. 2933 Long Beach Blvd. Long Beach, CA 90806 Accounts Receivable Manager. - Andrea Ferraco - Growth Opportunity

From pg. 4

My spouse had a strange relationship with his biological father, Lucio Gardea. It is possible that Lucio Gardea was convicted of a felony. However, I am not sure and he passed away two years ago.

Applicant's initial V. I. G.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 05-13-2020

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 Orthotics and Prosthetics
Nature of MDEG

Nevada Limb & Brace LLC 1505 Wigwam PKwy #141 Henderson, NV 89074
Name and Address of Business for Which MDEG Administrator Is Requested

Nevada Limb & Brace, LLC
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Gardea (Last Name) Vanis (First Name) Ingrid (Middle Name)

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

Coastal Fog Ave. Las Vegas, NV 89183 (Present Residence Address-Street or RFD / City / State/Zip)

1505 Wigwam Pkwy Dates Suite 141 Henderson, NV 89074 (Present Business Address / City / State/Zip)

Administrator/controller Dates July 2019 - Current (Present Position with the MDEG)

Phone: (702) 899-1700 Fax: (702) 899-1813

Email address: vanisg@NVLAB1.com

Date of Birth — San Salvador, El Salvador (Place of Birth (City, County, State))

44 (Age) — -- (Social Security Number or ITIN) — Female (Sex)

Brown (Color of Eyes) — Brown (Color of Hair) — 135 lbs. (Weight) — 5'2 (Height)

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

Are you a citizen of the United States? (Yes) No

If alien, registration No N/A

If naturalized, certificate . Date 09-17-2004

Place Los Angeles, California, U.S.A. (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.

Oct. Nov.
2000 - 2004 Human Designs P&O 2933 Long Beach Blvd. Long Beach, CA
Month and Year | Name/ Address of Employer/Business | No of Employed Hours

Accounts Receivable Manager - Claims Appeals Patient Financial Support Andrea Ferraro
Title | Description of Duties | Name of Supervisor

Sept. April
2013 - 2016 Ampro O&P 6877 S. Eastern Ave. Las Vegas, NV 89119
Month and Year | Name/ Address of Employer/Business | No of Employed Hours

Accounting Manager - Appeals - General Accounting Collections - Patient Financial Support Karen Jarvis
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: 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 please provide ...n.

.....

.....

.....

.....

.....

...RAPH

...AST

Date of photograph 05-13-2020

I, Vanis Ingrid Gardea, 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.

Vanis Ingrid Gardea
Original Signature of Applicant

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/6/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER TOM MOLLOY INSURANCE AGENCY 9708 Gillespie St. Suite A-104 Las Vegas, NV 89123	CONTACT NAME: TOM MOLLOY PHONE (A/C, No, Ext): (702)877-6888 FAX (A/C, No): (702)877-6242 E-MAIL ADDRESS: tom@tommolloyinsurance.com
INSURED Nevada Limb & Brace, LLC DBA: Nevada Limb & Brace 1505 Wigwam Pkwy # 141 Henderson, NV 89074	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: KINSALE INSURANCE CO INSURER B: THE HARTFORD INSURANCE COMPANY INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR INCLUDES PRODUCT LIAB & PROF LIAB. GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:	Y	Y	020729TM01	2/7/2020	2/7/2021	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 50,000 $ $ 2,000,000 $ 5,000,000 $ 5,000,000
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [Y] N/A If yes, describe under DESCRIPTION OF OPERATIONS below			53WECAF2F1V	2/1/2020	2/1/2021	[ ] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

SALES AND MGF OF PROSTETIC LIMBS AND BRACES.
INSUREDS PREMISES LOCATED AT 1505 WIGWAM PKWY # 141. HENDERSON , NV 89074.

CERTIFICATE HOLDER

FOR INFORMATION PURPOSES ONLY

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Tom Molloy