12A



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 (Please pr		Location Change MP01163
☐ Non Publicly Trad		ship - Pages 1,2,3,6 wner – Pages 1,2,3,7 of the application.
GENERAL INFOR	RMATION to be completed by all types of ownersh	nip
MDEG Name:	ActivStyle, Inc.	
Physical Address:	3500 Lakeside Ct Ste 200 Reno, NV 8 (This must be a business address, we can not issue a license to a home address)	19509-4829 ress)
Mailing Address: _	220 W Germantown Pike Suite 250	
City: Plymouth	Meeting State: PA Zip	Code: 19462
Telephone: 612-9	Meeting State: PA Zip 0 928-6826 Fax: 866-301-2167	
	ng@adapthealth.com Website: www.acti	
DAYS AND HOUR	RS THAT THE FACILITY WILL BE REGULARLY OF	ERATING
Mon: $\frac{8:00}{to}$ to $\frac{4:3}{1}$	Tue: 8:00 to 4:30 Wed: 8:00 4:30 Thu: 8:0	Qo 4:30
Fri: 8:00 4:3 Sa	at: Closedto Sun: Closed Holidays:	Closed
MDEG ADMINISTE	RATOR INFORMATION (MDEG administrator applic	cation required)
Name: Just	tin Garcia	
TYPE OF MDEG P	PRODUCTS THAT WILL BE SOLD (CHECK ALL A	PPLICABLE)
	equipment** Orthotics and Prose es Other: types of services you are required to have in place	a mechanism to ensure
	the event of an emergency. Provide name and telephose: 61	

This page must be submitted for all types of ownership.

	II Medicare and Medicaid provider numb 5720003-Medicare 1407173497-N		owner	
1)	Do any shareholders hold an interest or any type of business or facility which ar or another political jurisdiction?		Yes □	No 🗵
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?		Yes ⊠	No □
3)	Are any of the owners health profession Practitioner Advanced Practitioner of Nursing Physician's Assistant Physical Therapist Occupational Therapist Registered Nurse Respiratory Therapist	Name:		

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

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 🖾
attach	answer to questions 1 through 5 is "yes", a signed statement of explanation ed. Copies of any documents that identify the circumstance or contain an orer disposition may be required.	must be rder, agreement,
I unde	by certify that the answers given in this application and attached documentation are rstand that any infraction of the laws of the State of Nevada regulating the operation ized MDEG provider or wholesaler may be grounds for the revocation of this perm	n of an
penalty hereby any inv reputa	read all questions, answers and statements and know the contents thereof. I herely of perjury, that the information furnished on this application are true, accurate and authorize the Nevada State Board of Pharmacy, its agents, servants and employed vestigation(s) of the business, professional, social and moral background, qualification, as it may deem necessary, proper or desirable.	d correct. I ees, to conduct tion and
Origin	al Signature of Person Authorized to Submit Application, no copies or stamp	OS
Di	ane Siegel $7/10/20$	
Print I	Name of Authorized Person Date	
Board	Use Only Received: Amount:	3

List names of 4 largest partners and percentage of ownership:

OWNERSHIP IS A PARTNERSHIP

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

<u>Complete personal history record</u> 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.		Ste 200 Reno NV 89509		***************************************		
ActivStyle Inc.	Name a	and Address of Establishin	nent for Which Lice	nse Is Requested		
**************************************	• • • • • • • • • • • • • • • • • • • •	If applicable, Name Und	er Which It Is Now (Operated		
1. PERSONAL IN	NFORMATION:	Yehoshua				
Last Name N/A		First Name		Middle N	Name	
	aiden Name, Other Nar	ne Changes, Legal or Oth	nerwise)			
Sean Court,	Lakewood, N.					
Present Residence Add	ress-Street or RFD	C	City		State/Zip	
Germantov	vn Pike, Suit	Dates 8/16/17 to pr		mouth Meeting	PA 19462	
Present Business Addre	ess	Dates	City		State/Zip	
President		Dates 8/16/17 to	present			
Occupation				Phone Residen	Ct	=
	New York, Ki	ngs County, New York		Business	s 775-329-0799	
Date of Birth		Place of Birth (City, C	ounty, State)			983
41					Male	
Age	Social	Security Number	THE RESERVE		Sex	
Green B	rown Cau	casian	180	Healt	hy 6'3"	
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height	
	stinguishing marks	and/or characteristic	s None			
		Yes ⊠ No 🗆 If	alien, registrati	on No		
Place			(If natur	alized, docume	ent must be veri	fied.)
2. MARITAL INFO	ORMATION:					
Single Marri	ed ⊠ Separate	ed Divorced	□ Widowed	□ Engag	ged 🗆	1
				Applicant's	s initial	
				Applicant:	o ii iitiai	

A. Cui	rrent Ma	rriage		Date	***************************************					
Spo	ouse's fu	ıll name (N	laiden) 5	Date haidy Carlbach I	Parnes		City, Co S.S. N	unty and S	State	
Dat	e of Birt	h			Place of	f Birth			***************************************	*******
Res	sident ad	dress	Sean C	ourt, Lakewood	, P					
		*****	Street		*******	City	Stat	e Z	lip	
Tele	ephone	Residence	ce			Business				
Spo	ouse's er	mployer	Chemed H	lealth		Occupation.	APN			
Add	lress of	employer	1771 Mad Street	dison Ave, Lake	wood NJ 08	701 City	Stat	 e Z	lip	
B. Previo	us Marr	iages: If e	ever legally	separated, di	vorced, or	annulled, inc	licate belov	W .		
			of Order		of Place		ire of	City		
Name of Sp N/A	ouse	or [Decree	of M	arriage	Ac	tion	County	and State	
							- 1-1-1-1-1			
List		es, current		nd telephone r	numbers c	of previous sp State		Zip	Telephone	
N/A			Olicet		Oity	State		ZID	relephone	
				<u> </u>		A CONTRACTOR OF THE CONTRACTOR				
3. FAMILY	INFOR	MATION:								
A. Chi		obildren in		ep-children an	d adapted	obildron and	aliva tha fi		ind	
	Nam	P	Birth Date	Birth Pla	ace		Residen		<u>intormation:</u>	
Abraham Pari Ahuba Parn	n		usalem, Isra	el, Sean C Sean Court Lal		ood NJ 08701				
li Parnes	- 1			n Court, Lakewo						
ack Parne.		Lakewood		ean Court, Lake						
Shashona Par			ewood NJ,		t, Lakewood					
Miriam Parne	25	Lakev	N pook	Sean Court L	akewood N	J 08701				
B. Chi		ort Inform ase mark tl		nate response						
	I	am not su	bject to a	court order for	the suppo	rt of child				
	F	olan approv	ed by the	t order for the district attorne ursuant to the	y or other	one or more public agenc	children a y enforcin	nd am ir g the ord	n compliance ler for the re	e with a paymer
	t	he order o	r a plan ap	t order for the proved by the amount owed	district att	orney or othe o the order	children a r public ag Applicant's	ency en	in complian	ce with order for
								millal		Page
										_

	District attorney of	-Continued or public agency responsible	for enforcing the child s	upport order:	
				• •	
C.	Parents:	lence addresses, dates of bin			
arent	S-				,
	Name (Maiden)	ardian. If retired or deceased Birth Date	d, list last address and c Address	occupation.	Occupation
ather					
	d Parne	E h Street, Brooklyn, N	- Professor		
/lother		E Mistreet, Brooklyn, 14	-110163301		
Janet i	Parnes	: th Street Brooklyn NY	- Lab Manager		
ather-in	n-Law				
Jonah	Carlebach 1	Liberty Drive, Lakewood	NJ -Sales		
Nother-i Rache	in-Law el Carelbach	Liberty Drive, Lakewood	l. N. Teacher		
		5.55.7 51.10, Edite#000	, receiler		
Aaro	Name (Maiden) on Parnes	Birth Date Bro	Address poklyn, NY	self-employ	Occupation /ed
pouse Nech	nama Weiss	unknown		N/A	
	arnes	Bal	timore MD	Teacher	
pouse Brad	cha Leah Cohen	unknown		Teacher	
Shif	frah Garfunkle (Parn	es) la	kewood NJ	Speech Th	ora nict
pouse	hock Garfunkle	unknown	NEWOOD 143	Student	erapist
	auil Fischler		timore, MD		availet.
pouse	- Inches		timore, IVID	Physical Th	erapist
	uel Fischler	unknown		Social Worl	
	DUCATION:		1	Jocial Wolf	XCI
	Name of Sc	chool Location	n Dates Attended		Graduate
				1001	550
		DEUISIO I VALLINGS DI DIFFUNIO DI	1982 1982 1982	-1991	Yes 🛛 No 🗌
chool ligh	Mirrer Yeshiva Eler	h School 1791 Ocean Parkway B		-1995	
chool ligh chool ollege	Mirrer Yeshiva Eler Mirrer Yeshiva Higi Touro College 6th	h School 1791 Ocean Parkway B	rooklyn NY 11223 1991		Yes 🗵 No 🗆
chool ligh chool ollege iniversit	Mirrer Yeshiva Eler Mirrer Yeshiva Hig Touro College 6th		rooklyn NY 11223 1991 v York, NY 10010 1998-20		Yes 🔀 No 🗆
chool ligh chool ollege Iniversit	Mirrer Yeshiva Eler Mirrer Yeshiva Hig Touro College 6th	h School 1791 Ocean Parkway B 	rooklyn NY 11223 1991 v York, NY 10010 1998-20	00	
ichool ligh ichool college Iniversit	Mirrer Yeshiva Eler Mirrer Yeshiva Hig Touro College 6th Talmudic Law Sch	h School 1791 Ocean Parkway B A Avenue and West 23rd St, New 10 ol -BMG Lakewood NJ 08701	rooklyn NY 11223 1991 v York, NY 10010 1998-20 199	00 99-2003	Yes No No Yes No No No
School digh School College Universit Other	Mirrer Yeshiva Eler Mirrer Yeshiva Hig Touro College 6th Talmudic Law Sch	h School 1791 Ocean Parkway B AV enue and West 23rd St, New lool -BMG Lakewood NJ 08701 if any	rooklyn NY 11223 1991 v York, NY 10010 1998-20 199	00 99-2003	Yes No No
	Mirrer Yeshiva Eler Mirrer Yeshiva Hig Touro College 6th Talmudic Law Sch	h School 1791 Ocean Parkway B A Avenue and West 23rd St, New 10 ol -BMG Lakewood NJ 08701	v York, NY 10010 1998-20 199	00 99-2003	Yes No No No

5 MILITARY INFORMATION:

Α.	have you ever sen	red in any armed	forces?	Yes ⊔ N	o IXI	
	Branch		Date	of entry-activ	e service	
	Date of separation		Тур	e of discharge		
	Rating at separatio	n		Serial nun	nber	
	While in the military special or general or regardless of where	court martial?	Yes 🗆 No	☐ If yes, furr	vhich resulted in sui nish details on page	mmary action, a trial or 10. (List all incidents
В.,	Have you registere	d for the draft?	Yes □ No			
	County	Sta	te	Di	ate registered	
6. A	not convicted.) Have you ever bee violation for any rea	n arrested, detain ason whatsoever,	ed, charged, indi regardless of the	cted or summ	oned to answer for	s in which you were any criminal offense or t minor traffic citations.) otion.
Date of	Arrest Age	Charge	Location-City ar	nd State	Deposition/Date	Arresting Agency
B Cara	arrested or in which page 10. Have you ever beer or committee? Yes Have you ever beer commission? Yes □ Have you ever beer Yes □ No ☒ Have you ever had If yes, when? Have you ever recell f yes when? Has any member of	n questioned or d I □ No ☑ In subpoenaed to □ No ☑ In subpoenaed to □ subpoenaed to I a civil or criminal Inside a pardon or If your family or of	d as an unindicted eposed by a city, appear or testify testify for any civ record expunged city, deferred prosecucity, your spouse's fa	state, federal before a federal defense a federa	or law enforcement ral, state or county g administrative proce a court order? Yes ate	agency, commission grand jury, board or seding or hearing? No 🗅 No 🖎
lame		Relations				
		Relations		Charge	Loca	ation Date
	- 15 A D D D D D D D D D D D D D D D D D D					
					Applicant's initial	IN

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

1.

, co, g c co	s delow. List all cases with	nout exception, including ban	kruptcies:
intiff/Defendant or imant/Respondent	Court and Ca Date Filed Number	se City, County and S	tate Disposition/Date
			Tarana and America
associated with i		ctor or partner) been a party t	osely held corporation (while you voo a lawsuit, arbitration or bankrup
Name of Entity	Type of Entity	,	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
2000			
	ave had for the last 25 year	s:	
RESIDENCES: t all residences you hand Year From-To)	ave had for the last 25 year Street and Number	S: City	State or County
t all residences you ha	-	City	State or County
t all residences you ha oth and Year From-To) 003-2006	Street and Number 51 Lopsisey Lane,	City	State or County
all residences you ha th and Year (rom-To) 003-2006	Street and Number 51 Lopsisey Lane,	City Lakewood NJ	State or County
all residences you ha th and Year (rom-To) 003-2006	Street and Number 51 Lopsisey Lane,	City Lakewood NJ	State or County
all residences you ha th and Year rom-To) 003-2006	Street and Number 51 Lopsisey Lane,	City Lakewood NJ	State or County
t all residences you ha oth and Year From-To) 003-2006	Street and Number 51 Lopsisey Lane,	City Lakewood NJ	State or County
t all residences you ha	Street and Number 51 Lopsisey Lane,	City Lakewood NJ	State or County
all residences you ha th and Year From-To) 003-2006	Street and Number 51 Lopsisey Lane,	City Lakewood NJ	State or County

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	Rosson for Louisian
11/2004	Caring Distribution 5722 18th Ave Brooklyn New York	Reason for Leaving
		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 Lakewoo	od 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 Ada	aptHealth LLC (previously QMES LLC) 220 W Germantown Pike	e Suite 250 Plymouth Meeting PA 1946.
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 State Telephone Years Known Eli Friedman Chelsea Ct, Lakewood NJ 73 10 Name Home Employer Plains Capital LLC 428 Clifton Ave #100 Lakewood NJ 08701 732-886-6202 **Business** Danny Kagan Sean Court, Lakewood N 5 Home Employer **Business** Shmuel Peper Newbury Ct Lakewood NJ 08701 5 Name Home Employer **Business** Moshe Shapira Spruce St Lakewood NJ 08701 10 Name Home Employer **Business** Luke McGee 1 Spruce Street, Philadelphia, PA 19102 Name Home Quadrant Capital Management Employer Passaic Avenue Suite 301 Fairfield, NJ 07004 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 X 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 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 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 si any reason whatsoever? Yes □ No ☒	milar authority in or outside the State of Nevada for
14.	Have you ever been denied a personal license, permit, cer or professional activity? Yes □ No 凶	tificate or registration for a privileged, occupational
If yes	to the above, state where, when and for what reason:	
15.	Have you ever been refused a business or industry license participant in any group which has been denied a business suitability?	or related finding of suitability or been a or industry license or related finding of Yes □ No ☑
16.	Have you or any person with whom you have been a partic administrative action or proceeding relating to the pharmac	ipant in any group been the subject of an eutical industry? Yes □ No ☑
17.	Have you or any person with whom you have been a partic guilty or entered a plea of nolo contendere to any offense, controlled substances?	ipant in any group ever been found guilty, plead federal or state, related to prescription drugs and/or Yes □ No ☑
18.	Have you or any person with whom you have been a partic permit or certificate of registration relating to the pharmace upon voluntary close of a manufacturer	ipant in any group ever surrendered a license, utical industry voluntarily or otherwise (other than Yes □ No ☑
19.	Do you have any relatives within the fourth degree of consepharmaceutical or drug related industry?	anguinity associated with or employed in the Yes ☐ No ☒
		ate of photograph 1-13-20
		Applicant's initialPage 8

STATE OF NEW Jersly
SS.
COUNTY OF OCCOR
I, <u>Uehoshua Panes</u> , 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.
Was
Ortginal Signature of Applicant
Subscribed and Sworn to before me this 13 day of Tuly 2020
$\mathcal{N}_{N}}}}}}}}}}$
Notary Public
(seal)
(Joan)
NECHAMA KRAKAUER
Commission # 50083228 Notary Public, State of New Jerson
My Commission Expires May 24, 2023

Applicant's initial

ACORD

CERTIFICATE OF LIABILITY INSURANCE

5/17/2021

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).

this cer	tificate does not confer r	ights to the certificate holder i	n lieu of ຣເ	ch endorsement(s).			
PRODUCER	Lockton Companies	·		CONTACT NAME:			
	1185 Avenue of the Amer	icas, Suite 2010		PHONE (A/C, No. Ext):	FAX (A/C, No):		
	New York NY 10036 646-572-7300			E-MAIL ADDRESS:			
]	040-372-7300			INSURER(S) AFFORD	ING COVERAGE	NAIC#	
				INSURER A : Benchmark Insurar	nce Company	4139	4_
INSURED	ActivStyle, Inc.			INSURER B : Hartford Fire Insurar	nce Com an	1968	2
1422153	3500 Lakeside Ct, Ste 200	0		INSURER C			
	Reno NV 8959-4829			INSURER D			
				INSURER E			
				INSURER F			
COVERA	GES	CERTIFICATE NUMBER:	1683230	4 R	EVISION 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. ADDL SUBR TYPE OF INSURANCE LIMITS POLICY NUMBER COMMERCIAL GENERAL LIABILITY EACH OCCURRENCE s \$1,000 000 X D1019 G6279-1 Α 5 17 2020 5/17/2021 DAMAGE TO RENTED CLAIMS-MADE X OCCUR s \$1 000 000 PREMISES (Ea occurrence) s \$10,000 MED EXP (Any one person) PERSONAL & ADV INJURY s \$1,000,000 GEN'L AGGREGATE LIMIT APPLIES PER s \$3,000,000 GENERAL AGGREGATE POLICY PRODUCTS - COMP/OP AGG | \$ \$1,000,000 OTHER COMBINED SINGLE LIMIT AUTOMOBILE LIABILITY NOT APPLICABLE s XXXXXXX (Ea accident) ANY AUTO BODILY INJURY (Per person) \$ XXXXXXX OWNED AUTOS ONLY SCHEDULED BODILY INJURY (Per accident) \$ XXXXXX AUTOS NON-OWNED PROPERTY DAMAGE HIRED AUTOS ONLY s XXXXXXX AUTOS ONLY (Per accident) s XXXXXXX UMBRELLA LIAB X s \$10 000 000 OCCUR UM1019 6280-1 5 17 2020 5/17/2021 **EACH OCCURRENCE EXCESS LIAB** s \$10 000 000 CLAIMS MADE AGGREGATE DED RETENTION \$ s XXXXXXX WORKERS COMPENSATION NOT APPLICABLE STATUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT s XXXXXXX (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE \$ XXXXXXX if yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT | \$ XXXXXXX Prof Liab D1019 G6279-1 S1MM per occ S3MM agg 5 17 2020 5 17 2021 Blanket BPP 5 17 2020 5 17 2021 Limit \$58,939,860 39 UUN DF2446 DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIF	CATE	HOLE	DER

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 4 Calabrere

© 1988-2015 ACORD CORPORATION. All rights reserved.

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	Z	55413
AdaptHealth - Missouri LLC	Yehoshua Parnes	5436 Bleaux Ave, Ste A	Springdale	AR	72762-
AdaptHealth Patient Care Solutions Inc.	Vehoshua Parnes	600 Lindbergh Drive	Moon Township	PA	15108-
Advocate Medical Services, Inc. dba ActivStyle	Yehoshua Parnes	5912 Breckenridge Parkway Suite G	Tampa	2	33610
Aircare Home Respiratory LLC	Yehoshua Parnes	13311 Garden Grove Blvd, Ste D	Garden Grove	8	92843-
All American Home Aid, Inc. dba ActivStyle	Yehoshua Parnes	169 W Springfield St Unit B	Boston	¥₩	02118- 1403
American Ancillaries Inc	Yehoshua Parnes	4135 N Rancho Drive, Suite 110	Las Vegas	2	89130- 3494
Americoast Maryland LLC	Yehoshua Parnes	9321 Philadelphia Road, Suite K-L	Rosedale	MD	21237-
Associated Healthcare Systems, Inc.	Yehoshua Parnes	34 Riley Ave, Suite 3	Plattsburgh	ž	12901-
Bennett Medical Services	Yehoshua Parnes	2600 Mill Street, Suite 600	Reno	≥	89502-
Braden Partners, L.P.	Yehoshua Parnes	4882 McGrath St, Ste 220	Ventura	প্ৰ	93003-
Champlain Valley Brace & Limb LLC dba ActivStyle	Yehoshua Parnes	762 State Rte 3 Ste 15	Plattsburgh	ž	12901-
Choice Medical Healthcare LLC	Yehoshua Parnes	56 E Broadway, Ste 600	Salt Lake City	5	84111-
Clearview Medical Incorporated	Yehoshua Parnes	2503 Gravel Drive	Fort Worth	¥	76118-
First Choice Home Medical Equipment, LLC	Yehoshua Parnes	259 Quigley Blvd, Suite 1	New Castle	DE	19720-
Florida Home Medical Supply Inc dba Colonial Medical Supplies	Yehoshua Parnes	614 E ALTAMONTE DR	ALTAMONTE	교	32701- 4803
Gould's Discount Medical LLC	Yehoshua Parnes	3901 Dutchman's Lane, Suite 100	Louisville	≿	40207-
Halprin, Inc.	Yehoshua Parnes	2375 State Rd 332, Suite 1000	Canandaigua	ž	14424-
Healthline Medical Equipment, LLC	Yehoshua Parnes	4709 Lydia Dr	Wichita Falls	¥	76308-
Home Medical Express Inc.	Yehoshua Parnes	621 IL Route 83, Ste 101	Bensenville	=	60106-
Home MediService LLC	Yehoshua Parnes	540 S Union Ave	Havre de Grace	MD	21078-
					2410

Home Wellness, Inc. dba ActivStyle	Yehoshua Parnes	700 Route 130 N Suite 208	Cinnaminson	2	08077- 3366
Hometown Home Health U.C	Yehoshua Parnes	65 Salem Church Road	Jasper	В	30143- 5804
MARY Medical Inc. dba ActivStyle	Yehoshua Parnes	4656 E Dakota Avenue Ste 104	Fresno	క	93726- 4727
Med Way Medical, Inc	Yehoshua Parnes	1837 South 4130 West, Units A&B	Salt Lake City	5	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	ž	11577-
Ocean Home Health of PA Inc	Yehoshua Parnes	122 Mill Road, Suite A160	Phoenixville	PA	19460-
Ocean Home Health Supply LLC	Yehoshua Parnes	1000 Airport Road, Suite 101	Lakewood	2	08701-
Ogles Oxygen LLC	Yehoshua Parnes	1890 W Oak Pkwy, Ste A	Marietta	gA	30062-
Olean General Health Care Systems, LLC	Yehoshua Parnes	234 Homer Street	Olean	ž	14760-
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	2	08034-
Sleep Therapy LLC	Yehoshua Parnes	2157 Troop Drive, Suite 100	Sartell	Z	56377- 4563
Sleepeasy Therapeutics, Inc.	Yehoshua Parnes	3003 32nd Ave S, Ste 7C	Fargo	Q.	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	ř	78756-
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	Z.	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 A CHC'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 & CAPEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONER



+ 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 <u>dsiegel@adapthealth.com</u> 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 <u>dsiegel@adapthealth.com</u> 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

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 Non Publicly Traded Corporation – Pages 1.2,3,5a,5b ☐ Partnership - Pages 1,2,3,6 ☐ Sole Owner – Pages 1.2,3,7
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 ORTHULUS & FILMES / DBA EVOLUE PROSTHETICS & DETH
Physical Address: 601 Whyter Parest C-17 Hendelson W 69014 (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: 49014
Telephone: 702 898 6000 Fax: 702 898 -6080
E-mail: prosynes e guail. com Website: evolve pusthetics. 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: 6 to 5 Sat: 5 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** ☐ Assistive Equipment
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☐ Conthotics and Prosethics
Diphotic Supplies 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:
Page 1

This r	page must be submitted for all types of over	wnersnip.			
	Il Medicare and Medicaid provider numbe		ered to the business or its	s owner:	
	DILARE 4385780001				
1)	Do any shareholders hold an interest or any type of business or facility which ar or another political jurisdiction?	wnership e license	or have management in d by the State of Nevada	a Yes □ No â	X
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?	en associ MDEG pr	iated with any person. roducts were sold,	Yes □ No)	X
3)	Are any of the owners health profession	nals? If y	es, please check the box	cand list nam	ıe.
	Practitioner Advanced Practitioner of Nursing Physician's Assistant Physical Therapist Occupational Therapist Registered Nurse Respiratory Therapist	Name: Name: Name: Name: Name:	DAVID KOVACH CA		

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

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 interest, ever been the subject of an administrative action or proceed relating to the pharmaceutical industry?	
4)	Has the corporation, any owner(s), shareholder(s) or partner(s) with interest, ever been found guilty, pled guilty or entered a plea of not contendere to any offense federal or state, related to controlled substances?	
5)	Has the corporation, any owner(s), shareholder(s) or partner(s) with interest, ever surrendered a license, permit or certificate of registra voluntarily or otherwise (other than upon voluntary close of a facility	ation
attach	answer to questions 1 through 5 is "yes". a signed statement of explored. Copies of any documents that identify the circumstance or container disposition may be required.	anation must be ain an order, agreement,
I unde	by certify that the answers given in this application and attached document erstand that any infraction of the laws of the State of Nevada regulating the rized MDEG provider or wholesaler may be grounds for the revocation of the control of the revocation of the re	operation of an
penals hereb any in	e read all questions, answers and statements and know the contents thereonety of perjury, that the information furnished on this application are true, accurately authorize the Nevada State Board of Pharmacy, its agents, servants and exestigation(s) of the business, professional, social and moral background, ation, as it may deem necessary, proper or desirable.	urate and correct. I employees, to conduct
Origin	nal Signature of Person Authorized to Submit Application, no copies	or stamps
Origin	DAVID KOVACH 6/29/Ze	
Print	Name of Authorized Person Date	-
Board	d Use Only Received: Amount:	50000

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of	Incorporation: NV
	Company if any: DENHAM DRINGTLES & FITNESS
Corporat	tion Name: Evolue Prostitetics & ORTHOHICS
Mailing A	Address: 601 Whiting Rancot C-17
City: 14e	udusenState: Zip: Telephone:
	Fax: Contact Person: Dwio Kou key
702	798-4000 FAX-702898-4080
For any	corporation non publicly traded, disclose the following:
1) L	ist top 4 persons to whom the shares were issued by the corporation?
а	Name ROTHRURY AUE W, NV F9/4/
b	Name Address
C	Name Address
d	Name Address
record	All persons who are stockholders must accurately complete a personal history form. Download the form from the website under the "New Applications" tab. The forms ilable under the documents for all types of businesses.
2) F	Provide the number of shares issued by the corporation. 100%/2500
	What was the price paid per share? Undefermed
	What date did the corporation actually receive the cash assets? Dec 1014 1999
	Provide a copy of the corporation's stock register evidencing the above information

NON PUBLICLY TRADED CORPORATION

Include with the application for a non-publicly traded corporation

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.

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

List of officers and directors.

DAVID KOVACH - PRES.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

iDate 4/29/20

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 MDE6 L	ISCENSE			
DENHAM ORTHULS Nan RIOUR PROSITE	Rature of Nature	EVELVE PAL Tor Which License Is	Requested	AThetics
KNOWE PROSITE	If applicable Name Under V	MLCS Which It Is Now Opera	ted	
1. PERSONAL INFORMATION:	DAULD First Name		Awrito My Middle Name	
Last Name	First Name		Middle Name /	
Alias(es, Nicknames, Maiden Name, Other	Name Changes, Legal or Other	wise)		
P. HELLS. ALE	W.NV 89	141		
Present Residence Address-Sifeet or RFD	City		State/Zip	ſ
601 Why Ruch De C-17	Dates 2012- pus	just Hude	LSOM, NU 89	1014
Present Business Address	City	+	State/Zip	
Occupation PROS THETIST	Dates 2004- Pu	ufut	Phone	
Occupation			Residen	
	Calunit, M	1	Business 70Z	F28-4000
Date of Birth	Place of Birth (City, Cou	inty, State)		
44			n	<u> </u>
Age	ocial Security Number or ITIN	3		Sex
Blue Snow.	1 TAN	230	STUD LIKE	511
Color of Eyes Color of Hai	r Complexion	Weight	Build	Height
Scars, tattoos or distinguishing ma	arks and/or characteristics	5		
Are you a citizen of the United Sta	ates? Yes No If			
If naturalized, certificate No		Date		
Place		(If naturaliz	ed, document must b	e verified.)
2. MARITAL INFORMATION:				
Single Married Sep	parated • Divorced	→ Widowed -	● Engaged ●	
			Applicant's initial	DK
			Application initial_	Page

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	rent Marr	_	<u>.</u>	HL	Date	4	199: PERF	- 10/	,	City, Coun	ty and St.	nto.	
Spor	use's full	name (Maide	en)	KII					SS# or :			
Date	e of Birth						Place o	of Birth	LV,	NV	/.		
Res	ident add	ress_	580 S	treet	Lon	+BUR	y AVE	City	עא	State	t/ Zi	ip	
Tole	ephone:	Reside	nce					_Busines	s 70.	2 590	8-40	00	
	use's em			6	COR	P		_ _Occupa					
3pu	1056 5 611	hiokei.		<u> </u>	15			L		445	F		
Add	lress of e	mploye	S	Street	P47			City		State	Z	.ip	
B. Pr evio	us Marri	ages:	lf eve	r lega	lly sepa	arated. c	divorced, c	r annulle	d, indica	te below			
			te of C				of Place		Nature		City		State
ame of Sp	ouse		or Dec	ree		of N	Marriage		Action	1	County	/ and	State
													
Lis	t of name Nam			dress Street	and te	lephone	e numbers City	of previo	State	ses:	Zıp	Tele	ерһопе
3. FAMIL	Nam	MATIO	ON: ender	nts: luding Birth D	ı step-c	hildren	and adopt		State	ve the fo		ainfor	
3. FAMIL	Nam Y INFOR ildren ar List all Nam	e AMATIC nd Dep childre	ON: ender	nts:	ı step-c	hildren : Birth	City and adopt		State	ve the fo	ollowing	ainfor	
3. FAMIL	Nam Y INFOR ildren ar List all Nam	e AMATIC nd Dep childre	ON: ender	nts: luding Birth D	ı step-c	hildren : Birth	and adopt		State	ve the fo	ollowing	ainfor	
3. FAMIL	Nam Y INFOR	e AMATIC nd Dep childre	ON: ender	nts: luding Birth D	ı step-c	hildren : Birth	and adopt		State	ve the fo	ollowing	ainfor	

Page 2

Applicant's initial

FAMIL	Y 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,
parent	ts-
·	in-law or legal guardian. If retired or deceased, list last address and occupation. Name (Maiden) Birth Date Address Occupation
Father	
	Diceased
Mother	
J	BARKE KNAUM E. MONROE W, AN F910 Af
Father-i	
8.4-11	Dicensed
Mother-	PAT MOSS Huseume, Ut. N/A
D.	Brothers and Sisters: List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and
	their respective spouses. Name (Maiden) Birth Date Address Occupation
	CHRIS KOVACH . LUNV LIBIARIUM
Spouse	
^	
Spouse	е
Spouse	е
Spouse	Δ
Opous.	
4. E	EDUCATION:
-	Name of School Location Dates Attended Graduate
Gramn	of MI VIEW RELEASE LV, DV 63-03 Yes No
High	Elalare and 1/5 12/11/1 89-92
Schoo	98 - 140
Unive	ensity .
Other	
Туре	e of degree obtained, if any B.S. ATC
Colle	ege or university where obtained

Applicant's initial_

5 MIL	LITARY INFORMATION:
A.	Have you ever served in any armed forces? Yes
	BranchDate of entry-active service
	Date of separationType of discharge
	Rating at separationSerial number
	While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes No If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)
B.	Have you registered for the draft? Yes No
	CountyStateDate registered
6. Al	RRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.) Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations. Yes No 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
	VIA
	1971
В. С.	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 or page 10. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes No
D.	Have you ever been subpoensed to appear or testify before a federal, state or county grand jury, board or commission? Yes No
Ε.	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 lf yes, when?
G.	Have you everreceived a pardon or deferred prosecution for any criminal offense? Yes No lf yes when?city, county and state
Н.	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
	NA
	Applicant's initial

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

part to a laws	suit as either a p	member of a partnership plaintiff or defendant or a n divorces) st all cases without exc	an arbitration as eithe	r a claimant or r	rporation. ever been espondent?
intiff/Defendant or imant/Respondent	Date Filed	Court and Case Number	City, County and S	tate	Disposition/Date
		JA			
associated	with it as an owr	p, business venture, sol er, officer, director or pa mplete the following:	e proprietorship or cl artner) been a party t	o a lawsuit. arbi	tration or bankruptc
Name of Entity		Type of Entity		Approximate Date Lawsuit/Arbitration	
onth and Year (From-To)	ou have had for	the last 25 years:	City	State o	r County
Con	AM ST	W,NV 89141 W,NV 8914	/ Clark	2002	- pusut
1820 Virg	enia Aug	Lwenia	nt (2000 -	02
			-	Applicant's initia	l Pa

8. EMPLOYMENT:

4-2004	DEUMAN OF THE S & FILLIS	stockholder or related capacity.
onth and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
mostleles +	Custom Fab & deling of of	SELF/DENHAM
e	Description of Duties	Name of Supervisor
onth and Year	Name Mailing Address of Employer/Business	Reason for Leaving
2-04	Michya ORtho Jewes	ABIZ Wasser/M
moskfest/	Description of Duties Residut FAB & delay H 08 P	Name of Supervisor
Ionth and Year	Name Mailing Address of Employer/Business	Reason for Leaving
91-00	STAR NOVACARE	ScHOOL
itle	Description of Duties	Name of Supervisor
P.T. TEUH/	ATC Loundry/Maintence	- DEWHAM/ DAVE
lonth and Year	Name Mailing Address of Employer Business	Reason for Leaving
itle	Description of Duties	Name of Supervisor
Nonth and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
	Name Mailing Address of Employer Business	Reason for Leaving
lonth and Year	Name intaining Address of Employer Business	
	Description of Duties	Name of Supervisor
Month and Year Title Month and Year		Name of Supervisor Reason for Leaving
Title	Description of Duties	
Title Month and Year	Description of Duties Name Mailing Address of Employer Business	Reason for Leaving

9. CHARACTER REFERENCES:

	employer or employed There Employed	Street	City	State	Zip	Telephone		Years Kno	wn
	N HOWSTEN	Home		W,	NV				10
olover		Business							
	ESSE BERG	Home		4	ע אע				25
olover		Business							
	TEOF ZOGAD	-		4	vill				5
ployer		Business							
_	LLA FRAKES	Home		L	VNV		•		
ployer		Business							
	Ruy backell	Home		L	NNV	-			5
plover	1	Business							
	person's deposition of the person of the per	the followin	g: Location	1	City and State		Authorized User	rs	
11	Have you ever h	eld a privilege	ed accur	ationa	I or professional	license in	any state, incl	luding but n	not limited to
	Doctor	Lawyer Contractor Pilot	Race Real e Sports	horse/ estate t s prom	race dog owner broker or salesm		any state, incl Securities d Barber/Cosr Trainer or m	ealer netologist	Insurance Gaming Educator
	the following: Liquor Doctor Accountant Yes No If yes, state type Have you ever a interest in a lice	Lawyer Contractor Pilot where and y applied for a cinsed busines when and wimes and addi	Race Real e Sports years held years held ity, count as or indu	horse/ estate to some of the s	race dog owner broker or salesm oter	nture or indicate of Neva	Securities de Barber/Cosr Trainer or mainer or	ealer metologist nanager or held afir	Insurance Gaming Educator
	the following: Liquor Doctor Accountant Yes No If yes, state type Involved, the na	Lawyer Contractor Pilot where and y applied for a cinsed busines when and wimes and addi	Race Real e Sports years held years held ity, count as or indu	horse/ estate to some of the s	race dog owner broker or salesmoter ate business, ver UTSIDE the Stanames and locat	nture or indicate of Neva	Securities de Barber/Cosr Trainer or mainer or	ealer metologist nanager or held afir	Insurance Gaming Educator

13.	Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes
14.	Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes
yes	o the above, state where, when and for what reason:
45.	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
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?
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 noio 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?

*******	Date of photograph
	Applicant's initial UK
	Page 8

STATE OF NU	
COUNTY OF CLARK	SS.
	the state of the s
	being duly sworn, depose and say I have read the
foregoing application and know the contents thereof; that t	
contain a full and true account of the information requested	d may be deemed sufficient case for denial or revocation of
a manufacturer license; that I am voluntarily submitting this	
Statutes 639.210 (10) provides denial or revocation of the	
	ed any certificate, certification, license or permit by the filing
of an application, or any record, affidavit or other informati	
	Nevada Statutes on Pharmacists and Manufacturer and the
Controlled Substances Act, as amended, and the Regulat	ions of the Nevada State Board of Manufacturer as
promulgated thereunder and agree, if licensed, to abide the	iereby,
I hereby expressly waive, release and forever disc	charge the State of Nevada, the licensing agency and their
agents from any and all manner of action and causes of a	ction whatsoever which I. my administrators or executors
can, shall or may have against the State of Nevada, the li	censing agency and their agents, as a result of my applying
for a manufacturer license in the State of Nevada.	
	A
	Original Signature of Applicant
Subscribed and Sworn to before me this 30h	day of
Une, 2020	JUAN FLORES
0000	Notary Public, State of Nevada Appointment No. 19-6583-01
Notary Public	My Appt. Expires Dec 20, 2023
rectary i abite	(seal)

Applicant's initial_

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date W29/20

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 Orthorics & Parstmerics
Noture of MI) H(-
DENHAM ORTHOTICS & FILMES DEA EVOLVE PROSTAGICOS DETACTOS
Name and Address of Business for Which MDEG Administrator is Requested
FINEL DE PROSTHETICS & ORTHOTICS
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMA	ATION:		
Lovach Last Name	Dav 16 First Nar		Middle Name
Alias(es, Nicknames, Maid			
PATHRU	ie AUF W.	NU 89141	
Present Residence Addres	s-Street or RFD	City	State/Zip
LIAI Fededay Pauc	C-17 2012-2	t ilmeliser	N 49014
Present Residence Address LO L LUMY Rance Present Business Address	N Bales pura	City	State/Zip
Present Position with the 1	Dates 2019 7	peru	
Phone: 702 898 (1000 Fa	ax: 702 69	f 60 fo
Email address: 0.10 Pt	mes of Custo	1. com	
Email address:	1 de grande	11. 20.5	
	Calanet,	M	
Date of Birth	Place of Birth (City, County, State)	
44	1		M
Age	Social Security	Number or ITIN	Sex
P1. P.		230	T. 5'11"
Color of Eves Color		/eight	Height
•			-
Scars, tattoos or distinguis	hing marks and/or char	acteristics	
Are you a citizen of the Ur	ited States? Yes N	0 🖜	
If alien, registration No			
If naturalized, certificate N	0	Date	
Diago		(If naturalized	document must be verified
Place		(ii naturalized.	GOCUITIETH HIUST DE VEHINE

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.

April O4- Pus	ut Denham Orthotics Name/ Address of Employer/Business	37 740 No of Employed Hours
	Name/ Address of Employer/Business	No of Employed Hours
Prestides 1	SEEWO PANILY Evaluating 08P Description of Duties NUCLS	SELF/ DAVE DENHA
Title	Description of Duties Nuds	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Dutles	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

1.	I have 🖜	I have not	been charged,	arrested or cor	nvicted of a felony	y or misdem	neanor.
2.	I have *pending.	I have not	been the subje	ect of an admini	strative action wh	nether comp	eted or
3.	I have T	I have not	had a license s y action against	suspended, rev a professional	oked, surrendere license that was	d or otherw not made p	ise ublic.
			stions 1, 2 and/o		ude the following	information	and
	,	dministrative A	ction:	State:			
b)			Date:	11.00	No.	
				Case Numbe	r:		
С) Criminal	Action:		State:			
				Date:			
				Case Numbe	r:	- Little Hill	
				County:			
				Court:			
		i be actively in f the MDEG?	volved in and av	ware of the daily	y	Yes	No 🖜
	5 .Will you	be employed	fulltime with the	MDEG?		Yes	No 🖜
	6 .Will you during its n	be present at ormal operatin	the site of the Mg hours?	MDEG		Yes	No 🖜
If yo	ou answer N	lo to questions	4, 5 or 6 please	e provide a writ	ten letter of expla	nation.	
******				·····	ATTACH PHOT	OGRAPH	
					TAKEN WITH	IIN LAST	
		•••••			30 DAYS H	ERE	
				Date	of photograph		
			Page 4 – N	 MDEG Administ	trator		
			5				

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,

If you checked "I have" to questions 1, 2 and provide a written explanation and/or docume	d/or 3, please include the following information and ents.				
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?					
5 .Will you be employed fulltime with the	e MDEG?				
6 .Will you be present at the site of the MDEG during its normal operating hours?					
If you answer No to questions 4, 5 or 6 pleas	se providi A A A A A A A A A A A A A A A A A A				
	A DAVIGABITHE BY				
Page 4 – MDEG Administrator					

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

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



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 aim 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.



Certificate Number: B20200629891259

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

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 Secretary of State

Borbara K. Cegerste

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
Of Character Charles and All Metallians, the Man College Service and the Man All
☐ 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 de unt 10 das Vegas NV 8914. (This must be a business address, we can not issue a license to a home address)
A
Mailing Address: 3655 S. Durango da unit 10
City: Las Vegas State: NV Zip Code: 89147
Telephone: (702)6842415 Fax:
E-mail: Supply DFirstcaremedical, CRIVebsite:
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
9:00 5:00 9:00 5:00 9:00 5:00 9:00 5:00 Mon: AM to PM Tue: AM to PM Wed: AM to PM Thu: AM to PM
9:00 5:00 9:00 5:00 9:00 5:00 Mon: AM to PM Tue: AM to PM Wed: AM to PM Thu: AM to PM Fri: AM to PM Sat: to Sun: to Holidays: Closed
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Knarik Avagyan
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
☐ Medical Gases** ☐ Assistive Equipment
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☐ Orthotics and Prosethics
Diabetic Supplies 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 Avaguan Telephone: (702) 68424 15
Page 1

This page must be submitted for all types of ownership.

Mod	Il Medicare and Medicaid provider numb		the business or its		:
1)	Do any shareholders hold an interest or any type of business or facility which ar or another political jurisdiction?	wnership or have e licensed by th	e management in e State of Nevada	Yes □	No 🕅
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?	en associated w MDEG products	rith any person, were sold,	Yes □	No X
3)	Are any of the owners health profession	nals? If yes, ple	ase check the box	and list	name.
	☐ Practitioner ☐ Advanced Practitioner of Nursing ☐ Physician's Assistant ☐ Physical Therapist ☐ Occupational Therapist ☐ Registered Nurse ☐ Respiratory Therapist	Name:	N/A		
Praction	cing licensed health care professionals of	cannot obtain a l	icense per NAC 63	39.6943.	

OWNERSHIP IS A PUBLICLY	TRADED CORPO	RATION		
State of Incorporation:	NA	4		
Parent Company if any:				
Corporation Name:	the Ampienty stra	- li tu yayaya) italism) no ize n	
Mailing Address:	mar and selections	Great Following	and produces are	4 - 13
City:	State:	Zip:	+ 1 6,0 1,0 1-	/ - 25m
Telephone:		Fav.		A CONTRACTOR OF THE CONTRACTOR
License Contact Person:	The property of		1.768/10-9	
		T. P. 250 has		
Owner	rship Information –	Complete Sect	ion 1 or 2	
Do not use N/A i	in this section – Se	ection 1 or 2 n	nust he complete	ad .
2	hip)		%: %:	
3			%:	
4			%:	
Section 2: If the corporation that he corporation, the applicant shall ide registration with the SEC, the registraded. You can provide a copy of Date of Incorporation: Registration number issued: Stock Exchange:	entify the officers of the stration number issue fithe SEC report or co	at corporation, to d and the excha opy of Form 10-	he date the corpora inge at which the st K.	tion received its ock is being

Include with the application for a publicly traded corporation

List of officers and directors.

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

This page must be submitted for all types of ownership.

1)	Has the corporation, any owner, shareholder(s) or pa any interest, ever been charged, or convicted of a fel misdemeanor (including by way of a guilty plea or no	lony or gross	Yes □ No 🎾
2)	Has the corporation, any owner(s), shareholder(s) or any interest, ever been denied a license, permit or ce registration?	partner(s) with ertificate of	Yes □ No 🂢
3)	Has the corporation, any owner(s), shareholder(s) or interest, ever been the subject of an administrative acrelating to the pharmaceutical industry?		Yes □ No 🌣
4)	Has the corporation, any owner(s), shareholder(s) or interest, ever been found guilty, pled guilty or entered contendere to any offense federal or state, related to substances?	d a plea of nolo	Yes □ No 🌣
5)	Has the corporation, any owner(s), shareholder(s) or interest, ever surrendered a license, permit or certific voluntarily or otherwise (other than upon voluntary contents).	cate of registration	Yes □ No 🎘
attach	answer to questions 1 through 5 is "yes", a signed stated. Copies of any documents that identify the circumser disposition may be required.	tement of explanation retance or contain an ore	must be der, agreement,
I under	y certify that the answers given in this application and atta estand that any infraction of the laws of the State of Nevada zed MDEG provider or wholesaler may be grounds for the	a regulating the operation	n of an
penalty hereby any inv reputat	read all questions, answers and statements and know the of perjury, that the information furnished on this application authorize the Nevada State Board of Pharmacy, its agents estigation(s) of the business, professional, social and more ion, as it may deem necessary, proper or desirable.	on are true, accurate and s, servants and employed al background, qualificati	correct. I es, to conduct on and
Origina	al Signature of Person Authorized to Submit Application	on, no copies or stamp	S
	Jane of Authorized Person	<u>5-17-202</u> Date	0
Board	Use Only Received:	Amount:	

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

Stat	te of Incorporation:	Nevada
Pare	ent Company if any:	NIA
		Care Medical Supply LLC
Mail	ling Address: 3655 S	Durange de unit10
City	: Los Vegas	State: Zip: 1/V (702) 684-2 Telephone:
	J	Fax:Contact Person: KnaRiK Ava
For	any corporation non publicly tra	aded, disclose the following:
1)	List top 4 persons to whom	the shares were issued by the corporation?
	a) Knarik Avagy Name	an Rain Lily et dous Vegas NV 8
	b)	
	Name	Address
	c)	
	Name	Address
	d)	
	Name	Address
reco	<u>FE: All persons who are stocord form.</u> Download the form from from the documents	kholders must accurately complete a personal history rom the website under the "New Applications" tab. The forms of for all types of businesses.
2)	Provide the number of share	es issued by the corporation.
3)	What was the price paid per	r share?
4)	What date did the corporation	on actually receive the cash assets?
5)	Provide a conv of the cornor	ration's stock register evidencing the above information

NON PUBLICLY TRADED CORPORATION

Include with the application for a non-publicly traded corporation

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

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

List of officers and directors.

Knarik Avagyan

Page 5b

SECRETARY OF STATE



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.



Certificate Number: B20200417733620

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

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

FIRST CARE MEDICAL SUPPLY LLC

ENTITY NUMBER

E3592762019-7

FOR THE FILING PERIOD OF DEC, 2019 TO	DEC, 2020		
and the second s	DEC, 2020		
** YOU MAY FILE THIS FORM ONLINE AT ww	w.nvsilverflume.gov **		*100103*
Return one file stamped copy. (If filing not accompass stamped copy will be sent to registered agent.)	anied by order instructions, file		
IMPORTANT: Read instructions before completing and retu	rning this form.		
 Print or type names and addresses, either residence or business, f President, Secretary, Treasurer, or equivalent of and all Directors releast one director. An Officer must sign the form. FORM WILL BE 	nust be named. There must be at		
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 bas authorized stock as explained in the Annual List Fee Schedule For penalty must be added for failure to file this form by the deadline. A 90 days before its due date shall be deemed an amended list for the	Profit Corporations A \$75.00 An annual list received more than	ABOVE SPACE I	S FOR OFFICE USE ONLY
 State business license fee is \$500.00/\$200.00 for Professional Cor form by deadline. 	porations filed pursuant to NRS Chapter 89. Effective	ctive 2/1/2010, \$100.00 must b	pe added for failure to file
5. Make your check payable to the Secretary of State.			
6 Ordering Copies: If requested above, one file stamped copy will I A copy fee of \$2.00 per page is required for each additional cop accompany your order.	ne returned at no additional charge. To receive a y generated when ordering 2 or more file stamped	certified copy, enclose an addid or certified copies. Appropris	tional \$30,00 per certification in the instructions must
7. Return the completed form to: Secretary of State, 202 North Carso	ın Street, Carson City, Nevada 89701-4201, (775)	684-5708	
Form must be in the possession of the Secretary of State on or bef received after due date will be returned for additional fees and pen	ore the last day of the month in which it is due. (Falties. Failure to include annual list and business	Postmark date is not accepted license fees will result in reject	as receipt date.) Forms ion of filing.
CHECK ONLY IF APPLICABLE AND ENTER EXEMPTION	CODE IN BOX BELOW		
Pursuant to NRS Chapter 76, this entity is exempt from t	ne business license fee. Exemption code:	NRS 76.0	20 Exemption Codes
NOTE: If claiming an exemption, a notarized Declaration attach the Declaration of Eligibility form will result in rej	n of Eligibility form must be attached. Faction, which could result in late fees.		rnmental Entity 680B.020 Insurance Co
This corporation is a publicly traded corporation. The Ce	ntral Index Key number is:		
This publicly traded corporation is not required to have a	Central Index Key number.		
NAME	TITLE(S)		
KNARIK AVAGYAN		T (OR EQUIVALENT OF)	
ADDRESS	CITY	STATE	ZIP CODE
RAIN LILY CT	LAS VEGAS	NV	89117
NAME	TITLE(S)		
KNARIK AVAGYAN		RY (OR EQUIVALENT OF)	
ADDRESS	CITY	STATE	ZIP CODE
RAIN LILY CT	LAS VEGAS	NV	89117
NAME	TITLE(S)		
KNARIK AVAGYAN		R (OR EQUIVALENT OF)	
ADDRESS	CITY	STATE	ZIP CODE
AAIN LILY CT	LAS VEGAS	NV	89117
NAME	TITLE(S)		
KNARIK AVAGYAN	DIRECTOR	2	
ADDRESS	CITY	STATE	ZIP CODE
RAIN LILY CT	LAS VEGAS	NV	89117
None of the officers or directors identified in the list of officers hexercising the power or authority of an officer or director in furth I declare, to the best of my knowledge under penalty of perjury, a category C felony to knowlingly offer any false or forged instru	rerance of any unlawful conduct.	t and acknowledge that ours	

Title Date **MEMBER** 05/19/2020 Signature of Officer or **Other Authorized Signature**

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



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 Betlevue, WA 98009 P: 800.562.8095 F: 425.453.8696

WWW.goGUS.COM



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
	S 1,490.97	6.00	\$ 75 00	S 1,415.97

Note:

Invoice Payment Due On: 5/30/20

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 Taxes:

\$185.00

\$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

FERSONAL RISTORT RECORD FOR PRAFMACY, MUEG & Wholesaler

1654

1 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 MD	IEG				
FIRST Care Medical	Supply L'Valor	e of License 5 5 0 i 3655 S 0 i	i Rangoda	unit 10 da	s Vegas
Name a	nd Address of Establish	ment for Which License I	s Requested		
	If applicable, Name Un	der Which It Is Now Oper	ated	••••	
1. PERSONAL INFORMATION:	1/ - 05	1/			
HVagyan Last Name	Knaki First Nam	K	1000		
N/A.			Middle Name		
Alias(es, Nicknames, Maiden Name, Other Na	ne Changes, Legal or Ol	therwise)	1414	-0:1-7	
Rain Lily Ct	(as Vega	\$	NV	89117	
Present Residence Address-Street or RFD 3655 S DURANGO dR	unit 10	Las Vegas	State ////	89147	
Present Business Address	Dates	City City	/V V	0// 1/	
	Dates	,	State	, ZIÞ	
Occupation	Dates		Phone: Residenc		
· 1: 1 2 1	A small of a	Yerevan		02) 684 2	1415
Date of Birth		<u>* </u>	busilless [7	-	
117	Place of Birth (City, C	County, State)			
Age Social:	Secu	_		<u> </u>	
1	Jecui .	100		Sex	
DROWN Color of Eyes Color of Hair	Complexion	/ O U Weight	Build	5'7"	
,	Обліріскіоп	weignt	Dullu	Height	
0					_
Scars, tattoos or distinguishing marks	and/or characteristi	cs	1010		_
Are you a citizen of the United States?	Vas - No K	falian registration			••••
	162 - 1101-	i alien, registration r	VC		-
If naturalized, certificate No		Date			
Place		(If naturalize	ed, document mu	st be verified.)	
2. MARITAL INFORMATION:					
Single • Married • Separate	d 🖚 Direcci I	¥ 1000			
omgie o iviameu • Separate	Divorced	Widowed	Engaged -	•	
			Applicantle in the	Ald	
			Applicant's initia	11 / 14 ()	Page 1

Date of Order of Place Nature of City Action County and State List of names, current address and telephone numbers of previous spouses: Name Street City State Zip Telephone	Date	
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: Date of Order or Decree Of Marriage Action County and State Thure Graphanian D4-29-02 List of names, current address and telephone numbers of previous spouses: Name Street City State Zip Telephone	Spouse's full name (Maiden)	City, County and State SS# or ITIN
Telephone: Residence	Date of Birth	Place of Birth
Telephone: Residence	Resident address	
Spouse's employer		,
Address of employer Street Street City State Zip B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below: Name of Spouse Date of Order Or Decree Of Marriage Action County and State Athur Graphanian D4-29-02 List of names, current address and telephone numbers of previous spouses: Name Street City State Zip Telephone	Telephone: Residence	Business
B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below: Date of Order Date of Place Nature of City Name of Spouse Order Of Marriage Action County and State Chur Gapanian O4-29-02 CivoRceel Cas Vegas Clark List of names, current address and telephone numbers of previous spouses: Name Street City State Zin Telephone	Spouse's employer	Occupation
B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below: Date of Order		
Date of Order Date of Place Nature of City Name of Spouse or Decree of Marriage Action County and State Athur Gaplanian 04-29-02 divorced das Vegas, Clark List of names, current address and telephone numbers of previous spouses: Name Street City State Zin Telephone		
Name of Spouse or Decree of Marriage Action County and State Rthur Gaplanian 04-29-02 diverced das Vegas, Clark List of names, current address and telephone numbers of previous spouses: Name Street City State Zin Telephone		
List of names, current address and telephone numbers of previous spouses: Name Street City State 7in Telephone	Name of Spouse or Decree	of Marriage Action County and State
List of names, current address and telephone numbers of previous spouses: Name Street City State Zin Telephone	Rthur Gradanian	04-29-02 divorced das Vegas Clar
TRUMER GRAPHATIAN	List of names, current address and te	elephone numbers, of previous spouses:
	Name Street	City State Zin Telephone
	Name Street	City State Zin Telephone
	Arthur Craplaniar,	City State Zin Telephone
3. FAMILY INFORMATION: A. Children and Dependents:	Arthur Craplaniar, 3. FAMILY INFORMATION: A. Children and Dependents:	City State Zip Telephone MOOREROOFT ST das Vegas NV 89147
A. Children and Dependents: List all children, including step-children and adopted children and give the following information: Name Birth Date Birth Place Pecidence Address	3. FAMILY INFORMATION: A. Children and Dependents: List all children, including step-cl	City State Zip Telephone Mooreroft St das Vegas NV 89147 children and adopted children and give the following information:
A. Children and Dependents: List all children, including step-children and adopted children and give the following information: Name Birth Pale Birth Place Posidence Address	3. FAMILY INFORMATION: A. Children and Dependents: List all children, including step-cl Name Birth Date	City State Zip Telephone Mooreroft St das Vegas NV 89147 children and adopted children and give the following information: Birth Place Boordence Address
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A. Children and Dependents: List all children, including step-children and adopted children and give the following information: Name Birth Date Birth Place Posidence Address FRIK Khachatkyan ARmenia c/ Rain Lily et das Fabriel Gaplanian Los Angeles Rain Lily et das Veg	3. FAMILY INFORMATION: A. Children and Dependents: List all children, including step-cl Name Birth Date ERIK Khachatkyan	City State Zip Telephone Mooreroof St das Vegas NV 89147 children and adopted children and give the following information: Birth Place Peridence Address Armenia c' Rain Lily et das Los Angeles Rain Lily et das Veg
A. Children and Dependents: List all children, including step-children and adopted children and give the following information: Name Birth Date Birth Place Posidence Address FRIK Khachatzyan Armenia C/ Rain Lily et doss Rain Lily et doss Vega Rain Lily et doss	Arthur Craplaniar, 3. FAMILY INFORMATION: A. Children and Dependents: List all children, including step-cl Name Birth Date FRIK Khachatryan Fabriel Craplanian - Abriel Craplanian - Birth Date - Birth Date - Birth Date - Abriel Craplanian - Birth Date - Abriel Craplanian - Abriel Craplanian - Birth Date - B	City State Zip Telephone Mooreroof St das Vegas NV 89147 children and adopted children and give the following information: Birth Place Peridence Address Armenia c' Rain Lily et das Los Angeles Rain Lily et das Veg
A. Children and Dependents: List all children, including step-children and adopted children and give the following information: Name Birth Place Birth Place Posidence Address FRIK Khachatkyan Akmenia c' Rain Lily et dos	Arthur Craplaniar, 3. FAMILY INFORMATION: A. Children and Dependents: List all children, including step-cl Name Birth Date FRIK Khachatryan -abriel Craplanian B. Child Support Information:	City State Zip Telephone Mooreroof St das Vegas NV 89147 Children and adopted children and give the following information: Birth Place Address Admenia Los Angeles Rain Lily et dass Veg

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

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

Applicant's initial____

of the amount owed pursuant to the order; or

the repayment of the amount owed pursuant to the order.

WALLET ALL DESIGNATION CONTINUED

Add Cor C. Par List parents- in-la Nam Father Sam Mother Mother Father-in-Law Gabase Mother-in-Law dusib	thers ar	residence add al quardian. If Avagya Avagya Taplan Valbana	retired or Birth Date	decease decease decease decease	ed, list las Addre	st address	ARM ARM dos	enia enia Angel Vege	Occupation Occupation Assumers and sisters and
Cor C. Par List parents- in-la Nam Father Som Mother Mart Father-in-Law Gabrie Mother-in-Law dusib	ntact per ents: names, aw or lede (Maiden / e / thers ar names, respec	Avagya Avagya Avagya Taplan Valbana d Sisters: residence add	retired or Birth Date P A A A F A F A F A F A A F A A	decease decease decease decease	ed, list las Addre	st address	ARM ARM dos	enia enia Angel Vege	Occupation e s
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Sami Mother Mart Father-in-Law Gabrie Mother-in-Law List thei Nam	thers ar names,	Avagy Gaplan Valband d Sisters: residence add	an San San resses, da	deco de de	eeased eeased eeeas	d	ARM Los das	Angel Vege	as .
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Mother Mart Father-in-Law Gabrie Mother-in-Law Lusib D. Bro List their	thers ar names,	Avagy Gaplan Valband d Sisters: residence add	an San San resses, da	deco de de	eeased eeased eeeas	d	ARM Los das	Angel Vege	as .
Father-in-Law Gabase Mother-in-Law dussib D. Bro List thei Nam	thers ar names,	Taplan Valband d Sisters: residence add	ian lian resses, da	de d	c <u>e </u>	d	dos das	Angel Veg	as .
Mother-in-Law List Mam	thers ar names,	Valband d Sisters: residence add	resses, da	ites of bi	eceas irth and m	sed	das	Vegi	as .
D. Bro List their	thers ar names,	Valband d Sisters: residence add	resses, da	ites of bi	eceas irth and m	sed	das	Vegi	as .
List thei	names, <u>r respec</u>	residence add				nost rece	ent occupati	ions of broth	ners and sisters and
Nam	<u>rrespec</u>	residence add ive spouses.				nost rece	ent occupati	ions of broth	ners and sisters and
Nam		ive spouses.	Birth	Date	0 -1-1				
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	H	vagyan				A			
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Anan	1/	TONKUR	Jan	7	/		Hamen	118	
0					<u>,,</u>				
Spouse									
Spouse									
Spouse									
4. EDUCA	TION:								
C	Nam	of School		Local	tion	Dates	Attended		Graduate
Grammar School	H	172		ARM	enia	19	180-19	985	Yes 🔏 No 🖜
High School	# /	72	4	ARME		19		990	V
College	1/	1 . 1	0 1	1/	11	- 110		10	Yes No
University	ال	ReVar	57	ate	Un	ivek	65174		Yes 🔻 No 🦜
Other								<u>_</u>	Yes No
Type of degr	ee obtai	ned, if any	Yaste	RS	dega	?ee	DR	ganic	chemista
College or u	niversity	where obtaine	d)		J	1	

Applicant's initial A.K.
Page 3

A.	A. Have you ever served in any armed forces? Yes	s To No							
	BranchDate of entr	Date of entry-active service							
	Date of separationType of discharge								
	Rating at separationSeri	al number							
	While in the military service were you ever arrested for an offer special or general court martial? Yes → No → If y regardless of where they occurred-foreign or domestic.)	ense which resulted in summary action, a trial or ves, furnish details on page 10. (List all incident							
B.	B. Have you registered for the draft? Yes - No X								
	CountyState	Date registered							
6. A	. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS not convicted.)	S: (Include those arrests in which you were							
Α.	· ·	ition of the event? (Except minor traffic citations							
Date of	e of Arrest Age Charge Location-City and State	Deposition/Date Arresting Agency							
	N/A								
B.	B. Has a criminal indictment, information or complaint ever beer arrested or in which you were named as an unindicted copage 10.	n returned against you, but for which you were no party? Yes To No H If yes. furnish details on							
C.		deral or law enforcement agency, commission							
D.	 Have you ever been subpoenaed to appear or testify before a commission? Yes 								
E.	E. Have you ever been suppoen aed to testify for any civil, crimin	al or administrative proceeding or hearing?							
F.	If yes, when?	and state							
G.	G. Have you ever received a pardon or deferred prosecution for lf yes when?city, county a	orany criminal offense? Yes - No *							
Η.	Has any member of your family or of your spouse's family ever lf you answer to any of the above questions (B through H) is you	ver been convicted of a felony? Yes - No							
Vame	ne Relationship Charg	ge Location Date							
	N/A								
		Λ							
		/1 /							

Applicant's initial H. K.

1.	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:
ointiff/	Defendant

laintiff/Defendant or laimant/Respondent	Court and Case Date Filed Number	City, County and State	Dianosition /Data
N/A	THE THE PARTY OF T	City, County and State	Disposition/Date
J. Has any genera	al partnership, business venture, sole	e proprietorship or closely bo	ld corporation (while you w
associated with) it as an owner, officer, director or pa	artner) been a party to a laws	uit, arbitration or bankrupt
Yes No	If yes, complete the following:		•
Name of Entity	Turn of Fully	Approxin	nate Date(s) of
Name of Entity	Type of Entity	Lawsuit//	Arbitration/Bankruptcy
	1		
RESIDENCES:			
t all residences you b	ave had for the last 25 years:		
	ave had for the last 25 years.		
nth and Year -rom-To)	Street and Number	City	State or County
12 - Present	Rain Lily C	+ Las Vegas	NV 89117
0 0		1	11/20118
09 - 2012	3125 W Reno Ave		100 8 9 110
08-2009	9516 TRAHORIA ST	t das Vegas	NV 89178
07-2008	9947 Antelope	anyon Las Vegas	8 NV 89147
02-2007	4417 Cinderella	Con does Veger	1111
	N	101	4/:/ 20 -0
01 - 2002	7E F Iwain Ave		ias NV 89109
99-2001	Armenia, Ye	Revan.	

Applicant's initial A. K.

Page 5

Page 6

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 LL3655 S. Durango dr. cmit Title Description of Duties Name of Supervisor Member administrator Knarik
Title Description of Duties Name of Supervisor
member administrator Knarik
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
Month and Year Name/Mailing Address of Employer/Business AAA Heatheare Products Inc 18529 Roseo Blvd, North Title, Description of Duties Name of Supervisor
Title. Description of Duties
clerk Responsible box patients oxders Anahit
Month and Year Name/Mailing Address of Employer/Business / Reason for Leaving
Name/Mailing Address of Employer/Business 1014-2018 Flamingo Hpparel 3950 Las Vegas Blvd.
Title - Description of Duties
salesperson seling Products Yori
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
Month and Year Name/Mailing Address of Employer/Business 4-1-2014 Sunget Center Pharmacy and Supply 5137 /2 Sunget Title 4 Description of Publics
Name of Supervisor
clerk Responsible for patients orders Vardan
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
2015-2016 EWG EXPRESS LLC 38245 Jones Blvd. suit K
Trume of dapervisor
manager setting time talks and cango UnaxiK
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
2006-2012 Charisma 3000 Paradisc Rd das Vegas 89109
Description of Duttes Name of Supervisor
Solespenson 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
Title Description of Duties Name of Supervisor
Receptionist answering and directing calls Vormare
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving
2003-2005 Regis Signature 3770 S Las Vegas Blud.
Title Description of Duties Name of Supervisor
Keceptionist answering and directing calle Flory
If additional space is needed, continue on page 10 or provide attachment.
Applicant's initial $\mathcal{A}_{\epsilon}\mathcal{K}_{\epsilon}$

	List five charac employer or em		ho have know	you five years or	more. Do not	include relativ	es, present	
	Where Employed	Street	City Stat		Telephone		Years Known	
Name -	3tella	Mask	eal Duck K	as Vegas NV89	117		19	years
Employe	Pharmaci	st Business	Albert					
Name	Karine	nome	4 0 -	leights doust	0			18 years
Employe	r Owner	Business	Bridal E	legance an	1 Tuxedos	,		
Name	Sousanna	Home	das Veg	cas NV 89117			10	4cars
Employe	managen	R Business	MGM R	esorts In	<i>t.</i>			<u> </u>
Name	Naira	Home	Glendal		10,0,	•	_40	years Oyears
Employe	manager	Business	1V Hos	pice INC				
Name	Amy		Low Veg	9 as NV 8914	7			years
Emplove	ead Esthetic	cian _{Business}	Delano	Hotel	,			
10.	Do you have ar person's depos If yes, complet	sitory?Yes 🤜	► No ⊁	uch depository, a	ccess to any d	epository or d	o you use ar	ny other
Box Num	ber or Type of Depo	sitory	Location	City and State	Au	thorized Users		
11.	Have you ever the following: Liquor Doctor Accountant Yes No If yes, state typ	Lawyer Contractor Pilot	Race horse Real estate Sports pron	al or professional /race dog owner broker or salesm noter	Se an Ba	state, includin ecurities deale arber/Cosmeto ainer or mana	r Insu logist Gar	nited to urance ming ucator
12.	interest in a lice If yes, state type	ensed busines e, when and w ames and addr	s or industry C here and give	ate business, ven DUTSIDE the Stat names and locatio ers and the agend	e of Nevada? ons of the busi	Yes To No inesses in which	ch you were	
					Applic	cant's initial	A.K.	- , , Page 7

	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 To No
If yes I	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 X
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 X
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 X
	Date of photograph 5-2/-2020 Applicant's initial A, K.

Page 8

COUNTY OF CAR

I, Knark RVAGYAN, 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 filling 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

__day or

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_

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APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

10 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_	Med	ical	Equ	ipment	and	Supp	ly		
First	Care	Medi	cal	ature of MD	EGLLC	3655	DURANG	de	unit 10
Nam	ne and Add	lress of B	usiness	for Which N	IDEG Adm	inistrator Is	Requested	gas	NV 8914

If applicable, Name Under Which It Is Now Operated

1. PERSONAL I	NFORMATION:			1
Avagya, Last Name	n Kn	a R i K		Middle Name
Alias(es, Nickname	N/A es, Maiden Name, Other		, Legal or Oth	
Rai Present Residence		2015	Vegas City	NV 89117 State/Zip NV 89117
Present Business A	Address Dates Dates	City	Vegas	<i>N V 8 977 /</i> State/Zip
Present Position wi	th the MDEG	-		
Pho		Fax:		
Email address:	supply QFirst	earemed;	cal	
Date of Birth	AR n Place of E	1en Î.A. Birth (City, Coun	ty, State)	
Age		curity Number o	r ITIN	Sex
BROWN Color of Eyes	BROWN Color of Hair	<u>/6 0</u> Weight		Height
Scars, tattoos or dis	stinguishing marks and/c	r characteristics		ne
Are you a citizen of	the United States? Ye	s No		
If alien, registration	No	<u></u>		
If naturalized, certifi	cate No	Date		
Place		(If no	aturalized doc	ument 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.

1- 1- 2020 Month and Year	First Care Medical Supp Name/ Address of Employer/Business	14 LLC 3655 S. Puran
1	Name/ Address of Employer/Business	No of Employed Hours
member		KnariK
Title	Description of Duties	Name of Supervisor
6-6-19 Month and Year	AAA Healtheone Products Inc. Name/ Address of Employer/Business Responsible for patients on den	18529 Roseo Blvd. Nati
/	Name/ Address of Employer/Business	No of Employed Hours 52
clenK	Responsible for patients order	es Anahit
Title	Description of Duties	Name of Supervisor
4-1-2014	Sunget Conten Pharmaey and Supp Name/ Address of Employer/Business Responsible for patients orders	by 5137 1/2 Sunget Blue
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Clerk	Responsible for patients orders	· Vandan
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 ★ be or a physical condition that would license, including alcohol or subs	d impair my ability to	ated in the last five years fo perform any of the essenti	r a mental illness al functions of my
1. I have ▼ I have not 🗡 t	been charged, arrested or convicted of a felony or misdemeanor.		
 I have ▼ I have not ★ bending. 	peen the subject of a	an administrative action whe	ether completed or
 I have ▼ I have not ★ have not ★ have disciplined, including any and the disciplined. 	nad a license susper action against a prof	nded, revoked, surrendered Tessional license that was n	or otherwise ot made public.
If you checked "I have" to question or ovide a written explanation and	ons 1, 2 and/or 3, ple d/or documents.	ease include the following ir	nformation <u>and</u>
a) Board Administrative Action: b)		:	
		Number:	
c) Criminal Action:		:	
		Number:	
	Coun	ty:	
	Court	:	
4. Will you be actively involvoperation of the MDEG?	ved in and aware of	the daily	Yes 🗙 No 🖜
5 .Will you be employed fullt	ime with the MDEG	?	Yes 🕺 No 🕶
6 .Will you be present at the during its normal operating he	site of the MDEG ours?		Yes ★ No →
f you answer No to questions 4,		e a writ	+
	***************************************	Date of photograph 5	-21-2020

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

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 8907 (This must be a business address, we can not issue a license to a home address)
Mailing Address: 1505 Wigham Pkwy Svite 141 City: Henderson State: Nevada Zip Code: 89074
City: Henderson State: Nevada Zip Code: 89074
Telephone: (702) 899-1700 Fax: (702) 899-1813
E-mail: <u>Vanīsa@ NVLAB 1. com</u> Website: <u>NA</u>
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 to5:00 Sat: N-A to Sun: N-Ato Holidays: N-Ato
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Vanis Ingrid Gardea
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
THE STATE OF THE S
☐ Medical Gases** ☐ Assistive Equipment
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☐ Orthotics and Prosethics
Diabetic Supplies 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 Beih! Telephone: (702) 672 - 7971
Page 1

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List al	ll Medicare and Medicaid provider numb	ers registered to the business or its	s owner	•
	N-H		· · · · · · · · · · · · · · · · · · ·	
1)	Do any shareholders hold an interest or any type of business or facility which are or another political jurisdiction?	wnership or have management in re licensed by the State of Nevada		No 🗹
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?		Yes □	No 🗹
3)	Are any of the owners health profession	nals? If yes, please check the box	and list	name.
	 □ Practitioner □ Advanced Practitioner of Nursing □ Physician's Assistant □ Physical Therapist □ Occupational Therapist □ Registered Nurse □ Respiratory Therapist 	Name: Name: Name: Name: Name: Name: Name: Name:		

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Board (Use Only	Received:	Amount: 500,0	0
I have rependity hereby any inverse reputation of the control of t	read all questions, and of perjury, that the in authorize the Nevada estigation(s) of the bution, as it may deem not all Signature of Personal Signature	swers and statements and know the formation furnished on this application a State Board of Pharmacy, its agent usiness, professional, social and more ecessary, proper or desirable. On Authorized to Submit Application	contents thereof. I herel on are true, accurate and s, servants and employe al background, qualifica	by certify, under d correct. I dees, to conduct tion and
1 under	stand that any infracti	vers given in this application and atta ion of the laws of the State of Nevada or wholesaler may be grounds for the	a regulating the operation	n of an
attache	answer to questions ed. Copies of any de er disposition may b	1 through 5 is "yes", a signed sta ocuments that identify the circums e required.	tement of explanation stance or contain an o	must be rder, agreement,
5)	interest, ever surre	n, any owner(s), shareholder(s) or endered a license, permit or certific wise (other than upon voluntary o	cate of registration	Yes □ No 🗹
4)	interest, ever been	n, any owner(s), shareholder(s) or found guilty, pled guilty or entere offense federal or state, related to	d a plea of nolo	Yes □ No
3)	interest, ever been	n, any owner(s), shareholder(s) or the subject of an administrative a maceutical industry?	partner(s) with any ction or proceeding	Yes □ No ☑
2)	Has the corporation any interest, ever be registration?	n, any owner(s), shareholder(s) or coeen denied a license, permit or c	r partner(s) with ertificate of	Yes □ No ☑
1)	any interest, ever b	n, any owner, shareholder(s) or pa been charged, or convicted of a fe luding by way of a guilty plea or no	lony or gross	Yes □ No ☑

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
Owner's Name: Vanis Ingrid Gardeg 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

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

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

hi 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 Madical Device Equipment and Gases (MDEG)
Nevada Limb & Brace LL 1505 Wig wan Pkwy Suite 141 Henderson, NV 870 If applicable Name Under Which I is Now Operated
Name and Address of Establishment for Which License Is Requested
If applicable, Name Under Which It Is Now Operated
1 PERSONAL INFORMATION:
Last Name Van i S First Name Middle Name
Alias(ès, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)
- Coastal Fog Ave. Las Vegas NV 89183 Present Residence Address-Street or RED.
1505 Wigwam PKwyDates Henderson NV 89074 Present Business Address City State/Zip
3.00
Occupation Dates 2006 to Current
Occupation Phone: Residence
Date of Birth San Salvador El Salvador Business (702) 899-1700 Place of Birth (City, County, State)
44 °
Age Social Security Number of Hillin Sex
Brown Brown Medium 135 lbs. 512 Color of Eyes Color of Hair Complexion Weight Build Height
, and the state of
Scars, tattoos or distinguishing marks and/or characteristics N-A
Are you a citizen of the United States? Yes No • If alien, registration No
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 <u>↓.↓. G</u> Page 1

MARITAL	INFORMATION-Continued	

A.	Current Marria		nd, 2005	San Pedro. 1	os angeles, CA
	Spouse's full n	ame (Maiden) Rub	en anthon	y Garaleass#	County and State
	Date of Birth_			,	e California USA
	Resident addre	Street Coas	1 - ^	1	,
	Telephone: R	esidence		_Business (702)	899-1700
	Spouse's empl	over Trinity Or	thopedic, LL	Coccupation Pan	10 Technician - Ou
	Address of emp	oloyer 61 N. F	Pecos Rd	Suite 105 L	d O Technician - Ou as Vegas, NV 89101 State Ap
В. Р				or annulled, indicate be	U
Name	of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
N-	Α				
	Name	current address and t Street	telephone numbers City	of previous spouses: State	Zip Telephone
N-1	Α //				
3. FA	MILY INFORMA Children and D				
	List all chil	dren, including step-	children and adopte	d children and give the	e following information:
<u> </u>	Name	Birth Date	Birth Place	Resid	dence Address
Jak	riel Rub	\(\) \(\) \(\)	1	-	
Jai		ony Garde	29	- ,	
	Coast	al'tog Hv	e. Las Ve	egas, NV.	4.4
B.	Child Support Please	Information: mark the appropriate	e response:	U	
	■ l am	not subject to a cour	rt order for the supp	ort of child.	
	plan	subject to a court or approved by the dist e amount owed pursi	trict attorney or othe	r public agency enforc	and am in compliance with a ing the order for the repayment
	the o	subject to a court or order or a plan appro- repayment of the amo	ved by the district at	torney or other public to the order.	and NOT in compliance with agency enforcing the order for
				Applicar	nt's initial V. I. G

Page 2

FAMIL	LY INFORMATION-Continued
	District attorney or public agency responsible for enforcing the child support order: Name N - A
	Address
	Contact person
C.	Parents:
naront	List names, residence addresses, dates of birth and most recent occupations of parents, step-parents,
parent	in-law or legal guardian. If retired or deceased, list last address and occupation.
Father c	Name (Maiden) Birth Date Address Occupation
ادرو	
Mother	Mendoza Hospital Maintenance Flintlock Dr. Louisville, Ky
Edit	h Guzman 1 Flintlock Dr. Louisville, Ky
Jear Mother-i	onie Martin
Luci	
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
pouse	dia Rodriquez Via Della Cavallara "Monteviale VI, Italy-Honsenia
Juan Spouse	n Rodriguez Via Della Cavallan Monteviale, VI Italy. U.S. arm
Cì c	ly Gastelin Windemere Dr. Louisville, Ky-Homena Ke.
once	epcion Gastelum Windemere & Louisville, KY-Wanager
4. ED	DUCATION:
	Name of School Location Dates Attended Graduate
Gramma School	Limerick Ave Elementary Canoga Park CA 1983 - 1988 (Yes) - NO -
ligh ichool	John Freemant Wich las andles of 1991-1995
ollege	Cal State University Dominarca Hills and and
	Curson, CA Curson, CA
ther	Yes No The No
ype of	f degree obtained, if any Bachelor's Degree in accounting
College	e or university where obtained California State University, Dominguez Hills
	Applicant's initial 1. G.
	Page 3

5 MILITARY INFORMATION:

A.	Have you ever served in any armed forces?	Yes No
	Branch N - A Date	e of entry-active service
	Date of separationType	e of discharge
	Rating at separation	
	While in the military service were you ever arrested for special or general court martial? Yes No regardless of where they occurred-foreign or domestic	r an offense which resulted in summary action, a trial or If yes, furnish details on page 10. (List all incidents c.)
B.	Have you registered for the draft? Yes No	
	County N - A State	Date registered
6. AF	ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRA	
A.	not convicted.) Have you ever been arrested, detained, charged, indiviolation for any reason whatsoever, regardless of the Yes No If yes, give details in space provided	icted or summoned to answer for any criminal offense or disposition of the event? (Except minor traffic citations.) below. List all cases without exception.
Date of A	Arrest Age Charge Location-City and	nd State Deposition/Date Arresting Agency
N-	- A	
B. C. D. E. F. G.	arrested or in which you were named as an unindict page 10. Have you ever been questioned or deposed by a city, sor committee? Yes No Have you ever been subpoenaed to appear or testify the commission? Yes No Have you ever been subpoenaed to testify for any civil Yes No Have you ever had a civil or criminal record expunge If yes, when?	d or sealed by a court order? Yes occupantly and state No county a
Name	Relationship	Charge Location Date
Plea	ase refer to page 10.	
		Applicant's initial V. I. G. Page 4

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

	Defendant or VRespondent	Date Filed	Court and Case Number	City Courty and State	D: 21 /D /
Ni - F	\	Date Filed	Number	City, County and State	Disposition/Date
J.	associated w	ith it as an owne)	business venture, soler, officer, director or polete the following:	e proprietorship or closely held artner) been a party to a lawsuit	corporation (while you wer , arbitration or bankruptcy
	Name of Entity		Type of Entity		e Date(s) of itration/Bankruptcy
N -	10		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	LawsuitAit	ittation/Bankiuptcy
7 DE	SIDENCES:	1082			
		la accesa la accesa de la del	1		
	residences you	u have had for th	ne last 25 years:		
From-		Street	and Number	City S	tate or County
Lug	2019- Cu	rrent	Coastall	Tog Ave. Las Vega	S NV 89183
et.	2013 - 01	2019 025	20 Creae	Murtle CT Las 1	Leas. NV 8918.
va	2003- Qu	62013 22	39 Gale	Ave. Long Beach	CA 90810
ec	1995-	Que 2003	860/ Stat	le St. ap# Hg Sout	h Gate, CA 40:
			5.13 · · · · · · · · · · · · ·		
	C2-27 - 48			900	
				Appliance	
				Applicant's in	nitial V.I.G. Page

Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a

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	
Lly 2019-Current Nevada Limb & Brace, HC 1505 Wigwam Pkmy Soite 19	4
Henderson, NV 89074, administrator-Controller - Self	
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving Started my Comp	ar
June 2019- April 2010 Renu Oil of america - 5475 S. Valley View Title Description of Duties Name of Supervisor	
Blud. Las Vegas, NV 89118, Occounting Manager - Sophia Del Pozo	
Month and Year Warme/Mailing Address of Employer/Business Reason for Leaving 13 etter Opportun	1
May 2019- June 2019 Red Man, LLC 101 Convention Center Dr. Title Description of Duties Name of Supervisor	
7th Floor. Las Vegas, NV 89109 Ussistant Controller - Melissa lambso	ル
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving Entity Clo Sed	
Tept 2017- Nay 2019 MAK Enterprises, LLC 1950 Fast Mavle Name of Supervisor	
Las Vegas, NV 89119, Occounting Manager - Jennifer Turner	
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving Better op portuni	:4
april 2017-Sept 2017 Blue Diamond Machinery 2880 N. Nelly Title Pescription of Duties	,
Blvd. Las Vegas, NV 89115 - BookVeeper - Scott Paulo	
Month and Year Wame/Mailing Address of Employer/Business Reason for Leaving De oca tech	
Olori 2016-April 2017 Cannon Nevada, LLC 6671 S. Las Vegas Blud. Title Description of Duties Name of Supervisor	
Svite 210, las Vegas, NV 89119-Book Veeper-Scott Paulo	
Month and Year Name/Making Address of Employer/Business Reason for Leaving Entity Closed	
Month and Year Name/Making Address of Employer/Business Reason for Leaving Entity Closed Sept. 2013 - Upril 2016 Amore Orthotics of Prosthetics 68 77 S. Eastern Title Description of Duties 89/19 Name of Supervisor	
Ave. Las Vegas, NV, Occountant - Kaven Jarvis	
Month and Year Name/Mailing Address of Employer/Business Reason for Leaving Moved to Nevada	
Sept 2012 - July 2013 Lobe Financial 1150 N. Magnolia And. Title Description of Duties Name of Supervisor	
anahein, cA 92801 assistant Controller - Luz Hooper	
If additional space is needed, continue on page 10 or provide attachment. Confinued on by. 10.	
Applicant's initial V (G ₁ . Page 6	
rage o	

9. CHARACTER REFERENCES:

N-F)				
N-F) 				
11.	Have you even	r held a privilege	ed, occupational or professional license	in any state, including but i	not limited to
		Lawyer	Race horse/race dog owner	Securities dealer	Insurance
	Liquor Doctor Accountant Yes No	Contractor Pilot	Real estate broker or salesman Sports promoter	Barber/Cosmetologist Trainer or manager	Gaming Educator
N- F	Doctor Accountant Yes No	Contractor	Sports promoter		
N - F	Doctor Accountant Yes No	Contractor Pilot	Sports promoter		
N - F	Doctor Accountant Yes No If yes, state ty	Contractor Pilot pe, where and y	Sports promoter vears held	Trainer or manager	Educator
N - F	Doctor Accountant Yes No If yes, state ty Have you ever	Contractor Pilot pe, where and y r applied for a cit censed business	Sports promoter years held ty, county of state business, venture or is or industry OUTSIDE the State of Ne	Trainer or manager industry license or held a fir	Educator
N - F	Doctor Accountant Yes No If yes, state ty Have you ever interest in a lic If yes, state ty	Contractor Pilot pe, where and y r applied for a cit censed business pe, when and whames and addre	Sports promoter years held ty, county of state business, venture or i	Trainer or manager industry license or held a fir vada? Yes No	Educator

Applicant's initial V.I.G.

Page 7

N-A	any reason whatsoever? Yes No
14. U - A	Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupationa or professional activity? Yes
If yes t	to the above, state where, when and for what reason:
15. N -	participant in any group which has been denied a business or industry license or related finding of suitability?
16. N-Y	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
17. N =	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/of-
18. N - <i>I</i>	permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer Yes (No)
19. N - 1	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 05-12-2020 Applicant's initial 1.6, Page

STATE OF Nevada				
COUNTY OF Clark				
I, aris warted cardea, 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 12th day of May, 2020 by Vanis Ingrid Gardea. Notary Public KETH M. WILSON Notary Public - State of Nevada (seal/county of Clerk APPT. NO. 12-8836-1 My App. Expires Sept. 18, 2020				

From pg. 6 ADDITIONAL INFORMATION - Entity Closed	1682
May 2010-Sept 2012 active Storage Inc. 2295 Jefferson St Torrance, LA 90501 accounting Manager-Jane wike, CPA	
Qua: 2006 - May 2010 International Cable of Connectors - Charles 1 2400 E Valencia Dr. Ste D. Fullerton, CA 92831 CPV - Completed Degre	Brian,
april 2005- Clus 2006 SUS Enterprises Inc. 9030 Somerset Blud Bellflower, CA 90706 - accounts Payable and Receivable Manager - Growth Off	actuni t
Oct. 2000 - Nov. 2004 Human Designs Prosthetic and Orthotics. 2933 Long Reach Blud I Long Beach, CA 90806 Occounts Receivable Manager, - andrea Ferraco -Growth Opportuni	
My spouse had a strange, relationship with his biological father, Lucio Gardea It is possible that Lucio Giardea was convicted of a felony. However, I am not sure and he passed away two years ago.	

Applicant's initial V. I. G.

Page 10

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

hiDate 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, NV89074 Name and Address of Business for Whigh MDEG Administrator Is Requested
Name and Address of Business for Whigh MDEG Administrator Is Requested
Nevada Limb & Brace LC
Nevada Limb & Brace LLC If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Gardea Last Name	Vani S First Name	Ingrid Middle Name				
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)						
<u>Coas tal Fog Ave</u> Present Residence Address-Stre	eet or RFD City	State/Zip				
1505 Nigwam) Play Dates Suite 141 Henderson, NV 89074 Present Business Address V City State Zin						
Odminis trator (outro) Present Position with the MDEG	Pates July 2019 - Curren					
Phone: (702) 899-1700	Fax: (702) 899-18	313				
Email address: Vanisq@NI	ILABI 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 Color of Hair	Ueight	_ <u>5 ^ 2</u>				
Scars, tattoos or distinguishing marks and/or characteristics ν/A						
Are you a citizen of the United St	ates? Yes No •					
If alien, registration No N/A						
If naturalized, certificateDate _09-17-2009						
Place Los angeles, California, V.S. A (If naturalized, document must be verified.)						

Page 2 – MDEG Administrator

EMPLOYMENT:

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

Oct. No	ov.		
2000 - 2	1004 Hum	an Designs PbO 2933 long Beach	Blud. Lone Beach CA
Month and	l Year	Name/ Address of Employer/Business Patient Financial	No of Employed Hours
Occount	s Receiva	ble Manager-Claims appeals Description of Duties	andreg Ferraco
Title		Description of Duties	Name of Supervisor
Sept.	april		
2013 -	2016 am	pro D&P 6877 S. Fastern Ave	Las Vegas NV 89119
Month and	l Year	Name/ Address of Employer/Business	No of Employed Hours
Occount	ine Mana	ser = appeal - Treneral Accounti	no Karen hours
Title	0	Name/ Address of Employer/Business Collections-Patient Financia ser-appeals-General accounting 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 not been diagnose or a physical condition that would impair my license, including alcohol or substance abus	ed or treated in the last five years for a mental illness ability to perform any of the essential functions of my e,
1. I have 1 have not been charge	ed, arrested or convicted of a felony or misdemeanor.
2. I have not been the subpending.	oject of an administrative action whether completed or
 I have	e suspended, revoked, surrendered or otherwise ast a professional license that was not made public.
If you checked "I have" to questions 1, 2 and provide a written explanation and/or docume	/or 3, please include the following information and ents.
a) Board Administrative Action:b)	State:
5)	Date:
	Case Number:
c) Criminal Action:	State:
	Date:
	Case Number:
	County:
	Court:
4. Will you be actively involved in and a operation of the MDEG?	ware of the daily
5 .Will you be employed fulltime with the	MDEG? Yes No
6 .Will you be present at the site of the I during its normal operating hours?	MDEG Yes No •
If you answer No to questions 4, 5 or 6 please	e provide n.
	RAPH AST
	Date of photograph <u>0.5-13-2020</u>

Page 4 – MDEG Administrator

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

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

Original Signature of Applicant



CERTIFICATE OF LIABILITY INSURANCE

DATE AMADOM 1888 2/8/2020

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.

POSTANT- If the confidence holder is an ADDITIONAL INSURED provisions or be endorsed.

If the	SUBROGATION IS WAIVED, subjectis certificate does not confer rights	t to the	he te	rms and conditions of the pol licate holder in lieu of such en	icy, certain p dorsement(s)	olicies may	require an endorser	nent. A	statement on
_	NCER		des de la constante	SON Y	TOM M	OLLOY			
TOM MOLLOY INSURANCE AGENCY				FAIG.	PHONE FAX (702)877-8688 (AC. Not: (702)			2)877-6242	
970	8 Gilespie St. Suite A-104			S-MAII ADDRE	ns: tom@b		surance.com		
Las Vegas, NV 89123				INSURERES) AFFORDING COVERAGE				NAIC#	
				BISUR	BEREFRA: KINSALE INSURANCE CO				
Nevada Limb & Brace, LLC			BISUR	DISTREE B: THE HARTFORD INSURANCE COMPANY					
			DESUR	DISURER C:					
	DBA: Nevada Limb & B	race		nesus	MISURER D:				
	1505 Wigwam Pkwy #1	41		MISUR	MSURER E:				
	Henderson, NV 89074			DISUR	DISURER F:				
				NUMBER:			REVISION NUMBER		
CE	IS IS TO CERTIFY THAT THE POLICIE DICATED. NOTWITHSTANDING ANY I ERTIFICATE MAY BE ISSUED OR MAY ICLUSIONS AND CONDITIONS OF SUC	EQUI PER	REME TAIN	nt, term or condition of a The insurance afforded by	NY CONTRACT THE POLICE REDUCED BY	FOR OTHER ES DESCRIBE PAID CLAIMS	Document with Re D Herein is subject	SPECT T	D WHICH THIS
IMSR LTR	TYPE OF INSURANCE	Abou	WAD	POLICY NUMBER	POLICY EFF	POLICY ESP		LENETS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	\$	2,008,000
A	CLAMS-MADE X OCCUR			41			DAMAGE TO RENTED PREMISES (En occuments	5	58,000
	INCLUDES PRODUCT			1	1		MED EXP (Any one person) \$	
	LIAB & PROF LIAB.	Y	Y Y 020729	020729TM01	2/7/2028	2/7/2021	PERSONAL & ADVIMAR	Y 5	2,000,000
		-							

5,000,000 GENERAL AGGREGATE GENIL AGGREGATE LIMIT APPLIES PER: POLICY PRO- LOC 5,000,000 PRODUCTS - COMPYOP AGG \$ 5 OTHER: COMBINED SINGLE LIMIT AUTOMOBILE LIABILITY OTUA YMA **BODILY INJURY (Per person)** OWNED SCHEDULED AUTOS NON-OWNED AUTOS ONLY \$ **BODILY INJURY (Per accident)** AUTOS ONLY HIRED AUTOS ONLY PROPERTY DAMAGE \$ \$ UMBRELLA LIAB \$ OCCUR EACH OCCURRENCE PACESS LIAB CLAIMS-MADE AGGREGATE \$ DED \$ RETENTION\$ AND EMPLOYERS LIABILITY
AND EMPLOYERS LIABILITY STATUTE ANY PROPRIETOR PARTNER PROCUTIVE Y/N 1,000,000 EL EACH ACCIDENT B OFFICERMENTER EXCLUDED? Y 53WECAF2F1V 2/1/2020 2/1/2021 1,008,000 ELL DISEASE - EA EMPLOYEE \$ if yes, describe under DESCRIPTION OF OPERATIONS below 1,008,000 E.L. DISEASE - POLICY LIMIT

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	CANCELLATION				
FOR INFORMATION PURPOSES ONLY	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 Town In My				