

**NEVADA STATE BOARD OF PHARMACY**

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

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

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

**(non-refundable and not transferable money order or cashier's check only)**

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: MP or MW _____)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input checked="" type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> 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: IDEAL HEALTH CARE LLC

Physical Address: 2585 S JONES BLVD SUITE 1A LAS VEGAS NV 89164  
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 2062 MILLBURN AVE

City: MAPLEWOOD State: NJ Zip Code: 07040

Telephone: 973 762 4400 Fax: 973 762 3838

E-mail: Ahiny@idealhealthcarellc.com Website: Idealhealthcarellc.com

**DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING**

Mon: 8<sup>30am</sup> to 5<sup>p</sup> Tue: 8<sup>30</sup> to 5 Wed: 8<sup>30</sup> to 5 Thu: 8<sup>30</sup> to 5  
Fri: 8<sup>30</sup> to 5 Sat: \_\_\_\_\_ to \_\_\_\_\_ Sun: \_\_\_\_\_ to \_\_\_\_\_ Holidays: \_\_\_\_\_ to \_\_\_\_\_

**MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)**

Name: \_\_\_\_\_

**TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)**

- |                                                      |                                                              |
|------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Medical Gases**             | <input type="checkbox"/> Assistive Equipment                 |
| <input type="checkbox"/> Respiratory Equipment**     | <input type="checkbox"/> Parenteral and Enteral Equipment**  |
| <input type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> 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: RAJURGY Telephone: 928-680-4084

702 800-6520

100565

**APPLICATION FOR NEVADA MDEG LICENSE**

This page must be submitted for all types of ownership.

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

<u>4447870001</u>	<u>3218601</u>	_____
_____	_____	_____
_____	_____	_____

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes  No
- 2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes  No
- 3) Are any of the owners health professionals? If yes, please check the box and list name.

<input checked="" type="checkbox"/> Practitioner	Name: <u>Rakesh Jain (PO) LPO</u>
<input type="checkbox"/> Advanced Practitioner of Nursing	Name: _____
<input type="checkbox"/> Physician's Assistant	Name: _____
<input type="checkbox"/> Physical Therapist	Name: _____
<input type="checkbox"/> Occupational Therapist	Name: _____
<input type="checkbox"/> Registered Nurse	Name: _____
<input type="checkbox"/> Respiratory Therapist	Name: _____

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

**APPLICATION FOR NEVADA MDEG LICENSE**

This page must be submitted for all types of ownership.

Within the last five (5) years:

- 1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes  No
- 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes  No
- 3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes  No
- 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes  No
- 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes  No

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

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

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

*Rakesh Jain*  
Original Signature of Person Authorized to Submit Application, no copies or stamps

RAKESH JAIN  
Print Name of Authorized Person

03/24/18  
Date

<b>Board Use Only</b>	Received: _____	Amount: <u>\$ 500.00</u>
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**APPLICATION FOR NEVADA MDEG LICENSE**

**OWNERSHIP IS A PARTNERSHIP**

List names of 4 largest partners and percentage of ownership:

Name: Rakesh Jain %: 50  
Name: Padmini Jain %: 50  
Name: \_\_\_\_\_ %: \_\_\_\_\_  
Name: \_\_\_\_\_ %: \_\_\_\_\_

Partnership Name: Ideal Health Care LLC

Mailing Address: 2062 Milburn Ave

City: Maplewood State: NJ Zip Code: 07040

Telephone Number: 973 762 4400 Fax Number: 973 762 3838

Contact Person: Rakesh Jain

**PARTNERSHIP**

**Include with the application for a partnership**

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

# PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 3-24-18

## 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 Prosthetics & cosmetics  
 Nature of License  
Ideal Health Care LLC DBA mobility clinic  
 Name and Address of Establishment for Which License Is Requested  
2585 S. Jones Blvd. Suite A, Las Vegas, NV 89164  
 If applicable, Name Under Which It Is Now Operated

### 1. PERSONAL INFORMATION:

Last Name JAIN First Name PADMINI Middle Name \_\_\_\_\_  
 Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise) \_\_\_\_\_  
 Present Residence Address-Street or RFD 6 Farmhaven Ave. City Edison State/Zip NJ 08820  
 Present Business Address 2062 Millburn Ave. Maplewood, NJ City Maplewood State/Zip NJ 07040  
 Occupation owner/partner Dates October 2016 State/Zip NJ 07040  
 Date of Birth \_\_\_\_\_ Place of Birth (City, County, State) New Delhi, INDIA  
 Age 51 years Social Security Number \_\_\_\_\_ Sex Female  
 Color of Eyes Black Color of Hair Black Complexion Asian Weight 183 Build medium Height 5'3"

Scars, tattoos or distinguishing marks and/or characteristics Mole on the nose

Are you a citizen of the United States? Yes  No  If alien, registration No. Green Card

If naturalized, certificate No. \_\_\_\_\_ Date \_\_\_\_\_  
 Place \_\_\_\_\_ (If naturalized, document must be verified.)

### 2. MARITAL INFORMATION:

Single  Married  Separated  Divorced  Widowed  Engaged

Applicant's initial TJain

MARITAL INFORMATION-Continued

A. Current Marriage

Spouse's full name (Maiden) <sup>Date</sup> Rakesh Jain New Delhi, India  
City, County and State  
 Date of Birth \_\_\_\_\_ S.S. No. \_\_\_\_\_

Place of Birth New Delhi

Resident address 6 Farmhaven Ave Edison NJ 08820  
Street City State Zip

Telephone: Residence \_\_\_\_\_ Business 702 800 6520

Spouse's employer Ideal Healthcare Occupation Prosthetics/Cosmetics

Address of employer 2062 Milburn Ave Maplewood NJ 07040  
Street City State Zip

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

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

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

Name	Street	City	State	Zip	Telephone
N A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
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B. Child Support Information:

Please mark the appropriate response:

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

Applicant's initial RJ

**FAMILY INFORMATION-Continued**

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

Name .....  
 Address ..... NA .....  
 Contact person .....

**C. Parents:**

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

Name (Maiden)	Birth Date	Address	Occupation
Father			
Mother		Deceased	
Father-in-Law		Deceased - Sh. Prem Chand Jain	
Mother-in-Law		Deceased	

**D. Brothers and Sisters:**

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
Spouse Ravi Jain		9953/A St. 4 Saxi Rohilla, N. Delhi India	Retired
Spouse Mizdul Jain		" " "	Retired
Spouse Tapesk Kotia		" " "	Retired
Spouse Manju Jain		D-114 opp Ram Mandir Jain D-114 opp Ram Mandir Jain Pur, Raj India	Retired
Spouse Suman Jain		Deceased	
Spouse Parveen Jain		A-10 Shivdik New Delhi	Banker
Spouse Sanita Jain		" " "	H. maker

**4. EDUCATION:**

Name of School	Location	Dates Attended	Graduate
Grammar School			
High School			
School	Navhind Girls S. sec. Delhi	1984	Yes <input type="checkbox"/> No <input type="checkbox"/>
College	Delhi University, Delhi	1987	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
University			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other			Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any ..... High School Diploma .....

College or university where obtained ..... Delhi University .....

Applicant's initial ..... Jain .....

**5 MILITARY INFORMATION:**

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

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

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

Rating at separation ..... Serial number .....

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes  No  If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes  No

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

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

A. Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes  No  If yes, give details in space provided below. List all cases without exception.

Date of Arrest	Age	Charge	Location-City and State	Deposition/Date	Arresting Agency

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes  No  If yes, furnish details on page 10.

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes  No

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes  No

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

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

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

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

Name	Relationship	Charge	Location	Date

Applicant's initial BJ

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**ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued**

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

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

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

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

**7. RESIDENCES:**

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

Month and Year (From-To)	Street and Number	City	State or County
1967 to 1993	9953/A St. 4	Saxa Rohilla	New Delhi, India.
1993 to 1997	Phnom Penh,	Cambodia.	
1997 to 2002	C-399 Palam Ext.	New Delhi	India.
2002 to 2004	55 1/2 Belgrove Drive.	Kearney.	NJ
2004 to 2007.	106 Peach Street.	Avenel.	NJ 07001
2007 to 2017 Dec 23,	107 Calvert Ave.	Edison.	NJ 08820
2017 Dec 24, to current	6 Farm Haven Ave.	Edison.	NJ 08820

Applicant's initial P Jain

