NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$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 Pharmacy or ☑ Ownership Change (Provide current license number if making changes: PH C03284
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☑ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: United RX, LLC dba AbacusRx Pharmacy

Physical Address: 1516 W. Warm Sprigs Road

City: Henderson State: NV Zip Code: 89014

Telephone: 702- 475-4297 Fax: 855-298-6584

Toll Free Number: 844-248-9522 E-mail: kbcarlton@abacusrxnv.com

Website: N/A

Managing Pharmacist: Stephen Carlton License Number: 06471 ✓

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☑	☐ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☐	☑ Community	☑	☐ Long Term Care
☐	☑ Other: ____	☐	☑ Sterile Compounding
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding
	For the application to be complete	☐	☑ Other Services: ____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), 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, board citation, site fine 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 question 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 pharmacy 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.

Stephen W. Carlton

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

Stephen W. Carlton

Print Name of Authorized Person

2/28/18

Date

Board Use Only	Date Processed: _____	Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Illinois

Parent Company if any: United Rx,LLC

Mailing Address: 150 Fencil Lane

City: Hillside State: IL Zip: 60162

Telephone: 708-449-7600 Fax: 705-375-5760

Contact Person: Chuck Benain,RPh

For any corporation non publicly traded, disclose the following:

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

a) New York Boys Management, LLC 1230 Ridgedale Road, South Bend, IN 46614
Name Business Address

b) Charles Benain 150 Fencil Lane, Hillside, IL 60162
Name Business Address

c) A& F Realty 272 W. Tucker Drive. South Bend, IN 46624
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. 10,000

3) What was the price paid per share? _____

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 7 am 3am pm Saturday 8 am 10 pm

Sunday 8 am 10 pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20141548460

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, STEPHEN W. CARLTON

Responsible Person of ABACUS Rx PHARMACY

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Stephen W. Carlton

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

STEPHEN W. CARLTON

Print Name of Authorized Person

2/28/18

Date

Managing Pharmacist

Pharmacist Name: Stephen Carlton License #: 06471

Pharmacy Name: AbacusRx Pharmacy

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☑
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☑
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☑
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☑

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____
County _____ Court: _____

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

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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 Pharmacy or ☒ Ownership Change (Provide current license number if making changes: PH 1A02919

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b ☐ Partnership - Pages 1,2,6,10,11a&b

☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b ☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: CONCORDE TREATMENT CENTER, LLC. d/b/a DESERT HOPE TREATMENT CENTER

Physical Address: 2465 EAST TWAIN AVE

City: LAS VEGAS State: NV Zip Code: 89121

Telephone: (702) 848-6223 Fax: _____

Toll Free Number: _____ E-mail: nathen_connolly@yahoo.com

Website: deserthopetreatment.com

Managing Pharmacist: Nathen Connolly License Number: 18540 ✓

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☑	☐ Hospital (# beds 148)	☐	☑ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding
		☐	☑ Non Sterile Compounding
All boxes must be checked		☐	☑ Mail Service Sterile Compounding
For the application to be complete		☐	☑ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), 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, board citation, site fine 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 question 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 pharmacy may be grounds for the revocation of this permit.

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

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

Raul Gonzalez
Print Name of Authorized Person

4-18-2018
Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: Advanced Pharmaceutical Consultants, inc

Mailing Address: 9999 NE 2nd Ave Ste 315

City: miami shores State: FL Zip: 33138

Telephone: 305-751-7798 Fax: 305-751-7748

Contact Person: Andrea Mason

For any corporation non publicly traded, disclose the following:

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

a) Raul Gonzalez (Name) 9101 NE 2nd Ave miami shores, FL 33138 (Business Address)

b) Sue Fussler (Name) 9101 NE 2nd Ave miami shores, FL 33138 (Business Address)

c) Beverly Schummel Spenader (Name) 9101 NE 2nd Ave miami shores, FL 33138 (Business Address)

d) _____ (Name) _____ (Business Address)

2) Provide the number of shares issued by the corporation. N/A

3) What was the price paid per share? N/A

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 2:30 pm Saturday 8:00 am 1:30 pm

Sunday _____ am _____ pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20116101957

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

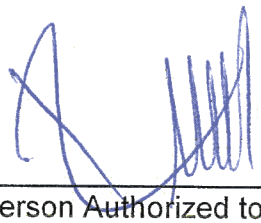
I, Raul Gonzalez

Responsible Person of Advanced Pharmaceutical Consultants, inc.

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.



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

Raul Gonzalez
Print Name of Authorized Person

4-18-2018
Date

Managing Pharmacist

Pharmacist Name: Nathen Connolly License #: 18540

Pharmacy Name: CONCORDE TREATMENT CENTER, LLC d/b/a DESERT HOPE TREATMENT CENTER

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☒
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☒
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

NEVADA STATE BOARD OF PHARMACY

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☑ New Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

- ☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
- ☐ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
- ☑ Partnership - Pages 1,2,6,10,11a&b
- ☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Las Vegas- AMG Specialty Hospital, LLC

Physical Address: 4015 S. McLeod Drive

City: Las Vegas State: NV Zip Code: 89121-4305

Telephone: 702-433-2200 Fax: 702-862-4435

Toll Free Number: _____ E-mail: jmcgee@amgihm.com

Website: amgvegas.com

Managing Pharmacist: Lane M. Cheramie License Number: 16613

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☑	☐ Hospital (# beds 24)	☐	☑ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☑	☐ Sterile Compounding
		☑	☐ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding
	For the application to be complete	☐	☐ Other Services: _____

1008916

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), 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, board citation, site fine 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 question 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 pharmacy may be grounds for the revocation of this permit.

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

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

August J. Rantz IV
Print Name of Authorized Person

05/02/2018
Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

Type of Partnership: General ✓ (LLC) Limited _____

List names of 4 largest partners and percentage of ownership:

Name: August J. Rantz IV %: 50

Name: Timothy Howard %: 50

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: Las Vegas - AMG Specialty Hospital, LLC

Mailing Address: 101 La Rue France, Ste. 100

City, State Zip Code: Lafayette, LA 70508

Telephone Number: 337-269-9566 Fax Number: 337-269-9823

Contact Person: Jessica McGee, CFO

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday _____am _____pm Saturday _____am _____pm

Sunday _____am _____pm 24 Hours ✓

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20151121058

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, August J. Rantz, IV

Responsible Person of Las Vegas - AMG Specialty Hospital, LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

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

August J. Rantz, IV
Print Name of Authorized Person

05/02/2018
Date

Managing Pharmacist

Pharmacist Name: Lane Cheramie License #: 16613

Pharmacy Name: Las Vegas- AMG Specialty Hospital, LLC

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☒
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☒
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____
County _____ Court: _____

NEVADA STATE BOARD OF PHARMACY

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☐ Partnership - Pages 1,2,6,10,11a&b
☑ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Nimble Pharmacy

Physical Address: 3864 Schiff Dr.

City: Las Vegas State: Nevada Zip Code: 89103

Telephone: (866) 966-4625 Fax: 650.889.4199

Toll Free Number: _____ E-mail: licensing@nimblerx.com

Website: www.nimblerx.com

Managing Pharmacist: Ralph Fiandra License Number: 8487 ✓

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☑	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☑ Hospital (# beds ____)	☐	☑ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding
	For the application to be complete	☐	☑ Other Services: _____

100566

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), 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, board citation, site fine 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 question 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.

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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.

Talh

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

Talha Waqar — Print Name of Authorized Person

03/27/18 — Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: _____

Mailing Address: 1134 Crane St. Ste. 100

City: Menlo Park State: CA Zip: 94025

Telephone: (866) 966-4625 Fax: 650.889.4199

Contact Person: Eva Ong

For any corporation non publicly traded, disclose the following:

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

a) Talha Waqar (Name) 1134 Crane St. Ste 100, Menlo Park, CA 94025 (Business Address)

b) _____ (Name) _____ (Business Address)

c) _____ (Name) _____ (Business Address)

d) _____ (Name) _____ (Business Address)

2) Provide the number of shares issued by the corporation. 100

3) What was the price paid per share? $0.01

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: _____

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, Talha Waqar

Responsible Person of Nimble Pharmacy

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

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

Talha Waqar
Print Name of Authorized Person

03/27/18
Date

Managing Pharmacist

Pharmacist Name: RALPH FIANDRA License #: 08487

Pharmacy Name: _____

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☒
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☒
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☒
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$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 Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☑ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Silver State Pharmacy LLC

Physical Address: 1074 Dove Eagle Ct

City: Las Vegas State: NV Zip Code: 89183

Telephone: (702) 335 1980 Fax: _____

Toll Free Number: _____ E-mail: silverstatepharmacy@gmail.com

Website: _____

Managing Pharmacist: Keoni Lacy License Number: 10681

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☒	☐ Retail	☐	☑ Off-site Cognitive Services
☐	☒ Hospital (# beds ____)	☐	☒ Parenteral
☐	☒ Internet	☐	☒ Parenteral (outpatient)
☐	☒ Nuclear	☐	☒ Outpatient/Discharge
☐	☒ Ambulatory Surgery Center	☐	☒ Mail Service
☐	☒ Community	☐	☒ Long Term Care
☐	☒ Other: _____	☐	☒ Sterile Compounding
		☐	☒ Non Sterile Compounding
All boxes must be checked		☐	☒ Mail Service Sterile Compounding
For the application to be complete		☐	☒ Other Services: _____

166466

May/04/2018

Hello Miss Candy

My name is Lizet Torres Leon, I'm applying for a new Pharmacy (Silver State Pharmacy LLC) this is my business location

1591 N. Buffalo Dr #140, Las Vegas, NV, 89128

Thank You very much

Lizet Torres Leon

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), 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, board citation, site fine 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 question 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 pharmacy 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.

LT

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

Liset Torres (CEO)

Print Name of Authorized Person

03/19/2018

Date

Board Use Only	Date Processed: _____	Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Mailing Address: 1074 Dove Eagle Ct

City: Las Vegas State: NV Zip: 89183

Telephone: (702) 335 1980 Fax: _____

Contact Person: Lizet Torres Leon

For any corporation non publicly traded, disclose the following:

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

a) N/A
Name Business Address

b) N/A
Name Business Address

c) N/A
Name Business Address

d) N/A
Name Business Address

2) Provide the number of shares issued by the corporation. Ø

3) What was the price paid per share? Ø

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: N/A %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9.00 am 6.00 pm Saturday closed am closed pm

Sunday closed am closed pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV 2018102117 6

STATEMENT OF RESPONSIBILITY – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, Lizet Torres Leon

Responsible Person of Silver State Pharmacy LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s)may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

LT

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

Lizet Torres Leon

Print Name of Authorized Person

03/19/2018

Date

Managing Pharmacist

Pharmacist Name: Kyeong Kang License #: 16681

Pharmacy Name: Silver State Pharmacy LLC

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	☐	☑
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☑
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	☐	☑
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☑

If you marked YES to any of the numbered questions above, please include the following information

Board Administrative Action: State: _____ Date: _____ Case #: _____

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____