19

19A

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE 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.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: DYL LLC South Lake Pharmacy

Physical Address: 38101 5th Ave

Mailing Address: Same as Physical

City: Zephyrhills State: Florida Zip Code: 33542

Telephone: 813.395.5667 Fax: 813.200.1122

Toll Free Number: 833.867.4024 (Required per NAC 639.708)

E-mail: Southlake.pharmacy@gmail.com Website: slcompounding.com

Managing Pharmacist: Hector Medrano License Number: PS35307

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: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE 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

HECTOR MEDRANO
Print Name of Authorized Person

1/31/2020
Date

Board Use Only Date Processed: FEB 13 2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: FLORIDA

Parent Company if any: NA

Mailing Address: 38101 5TH AVE

City: ZEPHYRHILLS State: FLORIDA Zip: 33542

Telephone: 813·395·5667 Fax: 813-200-1122

Contact Person: HECTOR MEDRANO

For any corporation non publicly traded, disclose the following:

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

a) _____
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

3) What was the price paid per share? NA

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

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

List any physician shareholders and percentage of ownership.

Name: NA %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6 pm Saturday 9 am 2 pm

Sunday closed am _____ pm 24 Hours _____

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

Must be included with the application for a non publicly traded corporation

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

List of officers and directors

HECTOR MEDRANO - MANAGING MEMBER 100% OWNERSHIP

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: HECTOR MEDRANO

Business Name: DNL SOUTH LAKE PHARMACY

Current Business Address: 38101 5TH AVE

City: ZEPHYRHILLS State: FLORIDA Zip Code: 33542

Telephone: 813.395.5667 Fax: 813.200.1122

List any physician shareholders and percentage of ownership.

Name: NA %:

Name: %:

Name: %:

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6 pm Saturday 9 am 2 pm

Sunday Closed am pm 24 Hours

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, HECTOR MEDRANO

Responsible Person of DYL 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

HECTOR MEDRANO
Print Name of Authorized Person

1/31/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF FLORIDA)
) ss.
PASCO COUNTY)

I, HECTOR MEDRANO, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the MANAGING MEMBER for DYL LLC (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out- of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, HECTOR MEDRANO, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
31ST day of January, 2020.

NOTARY PUBLIC

Notary Public State of Florida
Kerry Ann Nicklas
My Commission GG 108632
Expires 05/25/2021

State of Florida
Department of State

I certify from the records of this office that DYL LLC is a limited liability company organized under the laws of the State of Florida, filed on April 3, 2007, effective July 15, 2002.

The document number of this limited liability company is L07000035738.

I further certify that said limited liability company has paid all fees due this office through December 31, 2019, that its most recent annual report was filed on April 7, 2019, and that its status is active.

Given under my hand and the Great Seal of the State of Florida at Tallahassee, the Capital, this the Thirtieth day of January, 2020

GREAT SEAL OF THE STATE OF FLORIDA
IN GOD WE TRUST

Secretary of State

Tracking Number: 6040455487CU

To authenticate this certificate,visit the following site,enter this number, and then follow the instructions displayed.

https://services.sunbiz.org/Filings/CertificateOfStatus/CertificateAuthentication

AC# 8667905

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/29/2018	PH 31763	105265

The **PHARMACY**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **FEBRUARY 28, 2021**

D.Y.L. LLC
SOUTH LAKE PHARMACY
38101 5TH AVE
ZEPHYRHILLS, FL 33542

QUALIFICATION(S):
SPECIAL STERILE COMPOUNDING

Rick Scott
GOVERNOR

Celeste M. Philip, M.D., M.P.H.
Surgeon General and Secretary

DISPLAY IF REQUIRED BY LAW

1091

AC#8715875

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/29/2018	PH 24899	106679

The **PHARMACY** named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date: **FEBRUARY 28, 2021**

D.Y.L. LLC
SOUTH LAKE PHARMACY
38101 5TH AVE.
ZEPHYRHILLS, FL 33542

QUALIFICATION(S):
SCHEDULE II & III
COMMUNITY PHARMACY

Rick Scott
GOVERNOR

Celeste M. Philip, M.D., M.P.H.
Surgeon General and Secretary

DISPLAY IF REQUIRED BY LAW

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC# 8715875

DATE	LICENSE NO	CONTROL NO
12/29/2018	PH 24899	106679

The PHARMACY named below has met all requirements of the laws and rules of the state of Florida.
Expiration Date: FEBRUARY 28, 2021

D.Y.L. LLC

QUALIFICATION(S):
Schedule II & III
Community Pharmacy

EXPIRATION DATE: **FEBRUARY 28, 2021**

Your license number is PH 24899. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received you renewal notice 90 days prior to the expiration date shown on this license, please visit www.FLHealthSource.gov and click "Renew A Lic to renew online.

Medical Quality Assurance has a new and improved Online Services Portal. In the new system, you have the ability to renew your licens update your mailing and practice location addresses, request a name change, request a duplicate license and update your profile information all from the convenience of your online account.

1. Go to www.FLHealthSource.gov.
2. Click on "Provider Services" and select "Manage Your License."
3. Select your profession and license type and click "Submit."
4. The question "Have you Renewed or Applied Online Since 2015?" will display.
   a. Click on "No" if you have not registered for an account in the new system and follow the instructions provided for new use registration.
   b. Click on "Yes" if you are a returning user. Enter the user ID and password you selected during the registration process, th select "Sign In" to access your MQA Online Services Portal account.

IMPORTANT ANNOUNCEMENTS

Are You Renewal Ready?

The Department of Health will now review your continuing education records at the time of license renewal.

To learn more, please visit www.FLHealthSource.gov/AYRR

Grounds for Discipline

You should be familiar with the Grounds Discipline found in Section 456.072(1) Florida Statutes, and in the practice act f the profession in which you are license Florida Statutes can be accessed at www.leg.state.fl.us/Statutes

ARTICLES OF AMENDMENT
TO
ARTICLES OF ORGANIZATION
OF
DYL LLC

FILED
17 JUL 28 PM 1:16
DIVISION OF CORPORATIONS

Pursuant to the Florida Revised Limited Liability Company Act (the "**Act**"), **DYL LLC**, a Florida limited liability company (the "**Company**"), does hereby amend its Articles of Organization as follows:

FIRST: The name of the Company is **DYL LLC.**

SECOND: The original Articles of Organization of the Company were filed with the Florida Department of State on April 3, 2007, converting the Company from a Florida corporation to a Florida limited liability company.

THIRD: The document number of the Company is: L07000035738.

FOURTH: The Company's Articles of Organization are hereby amended as follows:

Article III of the Articles of Organization is deleted in its entirety and replaced with:

ARTICLE III

REGISTERED AGENT, REGISTERED OFFICE & REGISTERED AGENT'S SIGNATURE

The name of the Company's registered agent and the address of the Company's registered agent for service of process in Florida is:

Hector Medrano
38101 5th Ave.
Zephyrhills, FL 33542

I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligation of my position as registered agent. Or, if this document is being filed merely to reflect a change in the registered office address, I hereby confirm that the corporation has been notified in writing of this change.

Hector Medrano

Article IV of the Company's Articles of Organization is hereby deleted in its entirety and replaced with the following:

ARTICLE IV

MANAGER(S) OR MANAGING MEMBER(S)

The name(s) and address(es) of the manager(s) of the Company is (are):

Title:	**Name and Address:**
Manager	Hector Medrano 38101 5th Ave. Zephyrhills, FL 33542

FIFTH: The foregoing amendment was adopted on August 1, 2017.

IN WITNESS WHEREOF, the undersigned Managing Member of DYL LLC has executed these Articles of Amendment to Articles of Organization on this 1st day of August, 2017

DYL LLC

By: _____
Joseph Afolabi, its Managing Member

FILED
17 JUL 28 PM 1:16
DIVISION OF CORPORATIONS

19B

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE 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.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☒ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

LIMITED LIABILITY COMPANY

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: INFUCARE RX LLC

Physical Address: 2540 MARKET STREET, SUITE 1, ASTON, PA 19014

Mailing Address: PO BOX 2578

City: SECAUCUS State: NJ Zip Code: 07096

Telephone: (877) 828-3940 Fax: (877) 828-3941

Toll Free Number: (877) 828-3940 (Required per NAC 639.708)

E-mail: DBPATEL@INFUCARERX.COM Website: WWW.INFUCARERX.COM

Managing Pharmacist: ANDREW C. WEE, PHARM.D. License Number: RP439835

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: Specialty	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
All boxes must be checked		☒	☐ Mail Service Sterile Compounding **
For the application to be complete		☐	☑ Other Services: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE 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

DHARA PATEL
Print Name of Authorized Person

2/11/2020
Date

Board Use Only Date Processed: FEB 13 2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION (Limited Liability Company)

State of Incorporation: PENNSYLVANIA

Parent Company if any: INFUCARE RX INC

Mailing Address: PO BOX 2578

City: SECAUCUS State: NJ Zip: 07096

Telephone: (877) 828-3940 Fax: (877) 828-3941

Contact Person: DHARA PATEL

For any corporation non publicly traded, disclose the following:

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

a) INFUCARE RX INC (100% OF MEMBERSHIP INTERESTS) PO BOX 2578, SECAUCUS, NJ 07096
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. N/A - CO IS LLC - NO STOCK ISSUED

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

4) What date did the corporation actually receive the cash assets? N/A

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

List any physician shareholders and percentage of ownership.

Name: N/A - NO PHYSICIAN INTEREST HOLDERS %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

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

Sunday CLOSED am _____ pm 24 Hours NO

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

Must be included with the application for a non publicly traded corporation

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

List of officers and directors

DHARA PATEL, PRESIDENT/VICE-PRESIDENT/SECRETARY
SAJAL K. ROY, PHARM.D., VICE-PRESIDENT OF OPERATIONS

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, DHARA PATEL

Responsible Person of INFUCARE RX 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

DHARA PATEL
Print Name of Authorized Person

2/11/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF NEW JERSEY)
) ss.
ESSEX COUNTY)

I, DHARA PATEL, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the PRESIDENT for INFUCARE RX LLC (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out- of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, DHARA PATEL, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
11 day of February, 2020.

NOTARY PUBLIC

ADELA LUNGU
NOTARY PUBLIC OF NEW JERSEY
Comm. # 2423604
My Commission Expires 8/3/2022

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

11/12/2019

TO ALL WHOM THESE PRESENTS SHALL COME, GREETING:

I DO HEREBY CERTIFY THAT,

InfuCare Rx LLC

is duly registered as a Pennsylvania Limited Liability Company under the laws of the Commonwealth of Pennsylvania and remains subsisting so far as the records of this office show, as of the date herein.

I DO FURTHER CERTIFY THAT this Subsistence Certificate shall not imply that all fees, taxes and penalties owed to the Commonwealth of Pennsylvania are paid.

SECRETARY OF THE COMMONWEALTH PENNSYLVANIA

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Seal of the Secretary's Office to be affixed, the day and year above written

Kathy Boockvar

Acting Secretary of the Commonwealth

Certification Number: TSC191101141159-1

Verify this certificate online at http://www.corporations.pa.gov/orders/verify

861

Commonwealth of Pennsylvania Department of State
Bureau of Professional and Occupational Affairs

Pharmacy

License Number
PP482586

Expiration Date
08/31/2021

Active

INFUCARE RX
ANDREW C WEE
2540 MARKET ST STE ONE
ASTON, PA 19014

OFFICIAL DOCUMENT

READ THE FOLLOWING INFORMATION CAREFULLY CONCERNING YOUR LICENSE:

1. SIGN THE WALLET CARD AND CERTIFICATE WHERE INDICATED.
2. DETACH THE WALLET CARD AND CERTIFICATE AT PERFORATION.

Pennsylvania Licensing System (PALS)

Visit our website at: www.pals.pa.gov to renew your license, change your personal or license address, or order duplicate licenses.

INFUCARE RX
ANDREW C WEE
2540 MARKET ST STE ONE
ASTON, PA 19014

DISPLAY THIS CERTIFICATE PROMINENTLY • NOTIFY AGENCY WITHIN 10 DAYS OF ANY CHANGE

19 0832661

Commonwealth of Pennsylvania
Department of State
Bureau of Professional and Occupational Affairs
PO BOX 2649 Harrisburg PA 17105-2649

License Type
Pharmacy

INFUCARE RX
ANDREW C WEE
2540 MARKET ST STE ONE
ASTON, PA 19014

License Status
Active

Initial License Date
09/11/2015

Expiration Date
08/31/2021

License Number
PP482586

Acting Commissioner of Professional and Occupational Affairs

Signature

PA State Board of Pharmacy
PO Box 2649
Harrisburg, PA, 17105-2649
Phone: 717-783-7156 Fax: 717-787-7769

FACILITY

INFUCARE RX

2540 MARKET ST STE ONE

Aston, Pennsylvania, 19014

Phone:

Owner: INFUCARE RX LLC

LICENSE

License No: PP482586
Profession: Pharmacy
License Type: Pharmacy
Inspection Type: Non-Directed Routine
Inspection Date: 02/21/2019
Inspection Result: Passed

Remarks:

The undersigned licensee, designee, or other authorized representative of the licensee acknowledges the completion of this inspection and the results as indicated on the summary and checklist reports.

ALLEN WALCH	2/21/2019 2:52:45 PM	Andrew C Wee - RP439835
Signature of Inspector	Date/Time	Signature of Owner/Representative

19C

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE 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

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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.

☐ *Publicly Traded Corporation – Pages 1,2,3,7*
☐ *Partnership - Pages 1,2,5,7*
☑ *Non Publicly Traded Corporation – Pages 1,2,4,7*
☐ *Sole Owner – Pages 1,2,6,7*

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Revive Rx

Physical Address: 3831 Golf Dr. Ste A Houston, TX 77018

Mailing Address: 3831 Golf Dr. Ste A

City: Houston State: TX Zip Code: 77018

Telephone: (888) 689-2271 Fax: (888) 689-1620

Toll Free Number: (888) 689-2271 (Required per NAC 639.708)

E-mail: aaron@reviverxpharmacy.com Website: www.reviverxpharmacy.com

Managing Pharmacist: Aaron Schneider License Number: 51906

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: _____

****If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,**

APPLICATION FOR OUT-OF STATE 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

Aaron Schneider
Print Name of Authorized Person

10/21/19
Date

Board Use Only	Date Processed: FEB 05 2020	Amount: 500—

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General _____ Limited ✓

Partnership Name: REVIVE Rx, LLC

Mailing Address: 3831 GOLF Dr. STE A

City: HOUSTON State: TX Zip Code: 77018

Telephone Number: 888-689-2271 Fax Number: 886-689-1620

Contact Person: AARON SCHNEIDER

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

Name	G or L	Percentage
BRIGHAM BUHLER	L	70%
AARON SCHNEIDER	L	30%

List names of 4 largest partners and percentage of ownership:

Name: BRIGHAM BUHLER %: 70

Name: AARON SCHNEIDER %: 30

Name: _____ %: _____

Name: _____ %: _____

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6 pm Saturday 9 am 12 pm

Sunday closed am closed 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
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Aaron Schneider

Responsible Person of Revive Rx

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

Aaron Schneider
Print Name of Authorized Person

10/25/19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF_____)
) ss.
_____COUNTY)

I, Aaron Schneider, hereby certify that the assertions in this Affidavit are true and correct to the best of my knowledge and belief, and state as follows:

1. I am the Manager & PIC for Revive Rx (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out- of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Aaron Schneider, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Kelli Bailey / Kelli Bailey
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
___day of October, 2019.

Kelli Bailey
NOTARY PUBLIC

KELLI BAILEY
Notary Public, State of Texas
Comm. Expires 09-08-2021
Notary ID 131273593

Corporations Section
P.O.Box 13697
Austin, Texas 78711-3697

Ruth R. Hughs
Secretary of State

Office of the Secretary of State

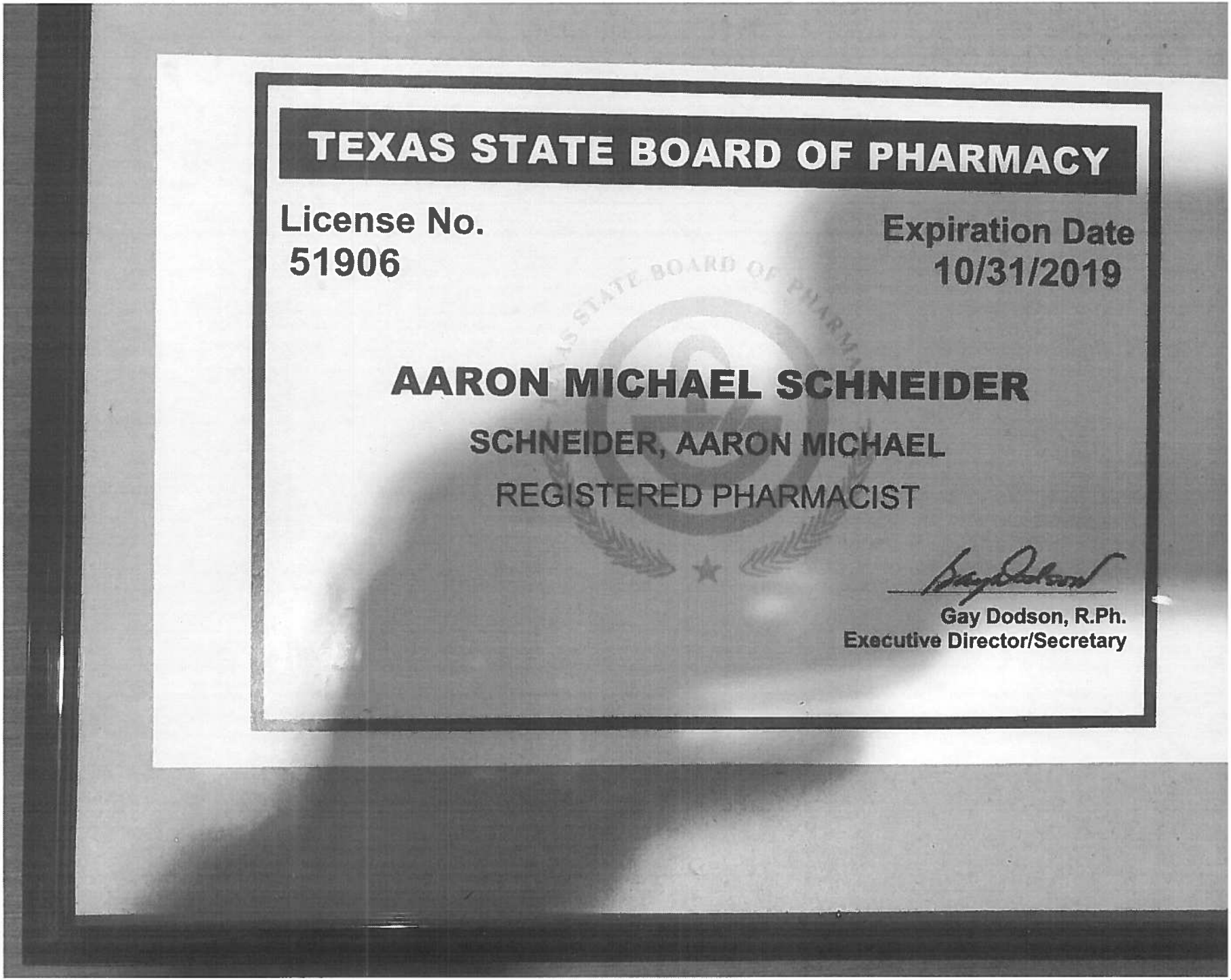
Certificate of Fact

The undersigned, as Secretary of State of Texas, does hereby certify that the document, Certificate of Formation for Revive Rx, LLC (file number 802428824), a Domestic Limited Liability Company (LLC), was filed in this office on April 05, 2016.

It is further certified that the entity status in Texas is in existence.

In testimony whereof, I have hereunto signed my name officially and caused to be impressed hereon the Seal of State at my office in Austin, Texas on December 11, 2019.

Ruth R. Hughs
Secretary of State


TEXAS STATE BOARD OF PHARMACY
License No.
51906
Expiration Date
10/31/2019
AARON MICHAEL SCHNEIDER
SCHNEIDER, AARON MICHAEL
REGISTERED PHARMACIST
Gay Dodson, R.Ph.
Executive Director/Secretary

Secretary of State
P.O. Box 13697
Austin, TX 78711-3697
FAX: 512/463-5709

Filing Fee: $300

Certificate of Formation
Limited Liability Company

Filed in the Office of the
Secretary of State of Texas
Filing #: 802428824 04/05/2016
Document #: 664235500002
Image Generated Electronically
for Web Filing

Article 1 - Entity Name and Type

The filing entity being formed is a limited liability company. The name of the entity is:

Revive Rx, LLC

Article 2 – Registered Agent and Registered Office

☐ A. The initial registered agent is an organization (cannot be company named above) by the name of:

OR

☑ B. The initial registered agent is an individual resident of the state whose name is set forth below:

Name:
Brigham Buhler

C. The business address of the registered agent and the registered office address is:

Street Address:
501 E. 23rd St. Houston TX 77008

Consent of Registered Agent

☐ A. A copy of the consent of registered agent is attached.

OR

☑ B. The consent of the registered agent is maintained by the entity.

Article 3 - Governing Authority

☑ A. The limited liability company is to be managed by managers.

OR

☐ B. The limited liability company will not have managers. Management of the company is reserved to the members.

The names and addresses of the governing persons are set forth below:

Manager 1: **Aaron Schneider, Pharm. D.** Title: **Manager**

Address: **501 E. 23rd St. Houston TX, USA 77008**

Article 4 - Purpose

The purpose for which the company is organized is for the transaction of any and all lawful business for which limited liability companies may be organized under the Texas Business Organizations Code.

Supplemental Provisions / Information

Only persons with a valid Texas Pharmacist License may be managers of the Company.

[The attached addendum, if any, is incorporated herein by reference.]

Organizer

The name and address of the organizer are set forth below.

Brigham Buhler **501 E. 23rd St. Houston, TX 77008**

Effectiveness of Filing

☑ A. This document becomes effective when the document is filed by the secretary of state.

OR

☐ B. This document becomes effective at a later date, which is not more than ninety (90) days from the date of its signing. The delayed effective date is:

Execution

The undersigned affirms that the person designated as registered agent has consented to the appointment. The undersigned signs this document subject to the penalties imposed by law for the submission of a materially false or fraudulent instrument and certifies under penalty of perjury that the undersigned is authorized under the provisions of law governing the entity to execute the filing instrument.

Brigham Buhler

Signature of Organizer

FILING OFFICE COPY

ReviveRX Pharmacy

List of all Owners, Officers or Directors of the Pharmacy with their names, addresses and D.O.B:

- Aaron Schneider – Manager
- **Address:** Trinity Bay City, TX 77414
- **D.O.B:**

- Brigham Buhler – Member
- **Address:** Coronado St. Houston, TX 77009
- **D.O.B:** 1

List of all pharmacists with their address, license numbers and D.O.B:

Aaron Schneider

License # 51906

Address: 1 Trinity Bay City, TX 77414

D.O.B: 1

Gina Stornelli

License # 61178

Address: . Richmond Ave Apt. 501 Houston, TX 77006

D.O.B: