20

NEVADA STATE BOARD OF PHARMACY

MP02974

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.

☒ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b
☐ Partnership - Pages 1,2,3,6
☒ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Nevada Prime Healthcare LLC

Physical Address: 3100 MILL ST #213B RENO NV 89502
(This must be a business address, we can not issue a license to a home address)

Mailing Address: SAME AS ABOVE

City: RENO State: NV Zip Code: 89502

Telephone: 775-375-8619 Fax: 775-571-1860

E-mail: Jkoler@nevadaprime.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 5 Tue: 9 to 5 Wed: 9 to 5 Thu: 9 to 5

Fri: 9 to 5 Sat: NA to Sun: NA to Holidays: NA to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: JARED KOLER

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

☐ Medical Gases**
☐ Respiratory Equipment**
☐ Life-sustaining equipment**
☐ Diabetic Supplies
☐ Assistive Equipment
☐ Parenteral and Enteral Equipment**
☐ Orthotics and Prosethics
Other: PNEUMATIC COMPRESSION DEVICE

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: _____ Telephone: _____

JK

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:

NPI 1225593262 _____ _____

NPI 1972132678 _____ _____

_____ _____ _____

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. NO

☐ Practitioner	Name: _____
☐ Advanced Practitioner of Nursing	Name: _____
☐ Physician's Assistant	Name: _____
☐ Physical Therapist	Name: _____
☐ Occupational Therapist	Name: _____
☐ Registered Nurse	Name: _____
☐ Respiratory Therapist	Name: _____

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

JR

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

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

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

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

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

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

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

JARED KOLEN
Print Name of Authorized Person

4/21/2020
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: JARED KOLER

Business Name: NEVADA PRIME HEALTHCARE LLC

Current Business Address: 3100 MILL ST Ste 21313

City: RENO State: NV Zip: 89502

Telephone: 775-375-8649 Fax: 775-571-1860

SOLE OWNER

Include with the application for a sole owner

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

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/04/2020

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

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

PRODUCER	CONTACT NAME:	
Hiscox Inc. 520 Madison Avenue 32nd Floor New York, NY 10022	PHONE (A/C, No, Ext): (888) 202-3007	FAX (A/C, No):
	E-MAIL ADDRESS: contact@hiscox.com	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Nevada Prime Healthcare LLC 3100 Mill St Ste 213B Reno NV 89502	INSURER A : Hiscox Insurance Company Inc	10200
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:			UDC-4175211-CGL-19	06/01/2019	06/01/2020	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ S/T Gen. Agg.
								$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [ ] RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A						[ ] PER STATUTE [ ] OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

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

CERTIFICATE HOLDER

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

1424

Date 4/21/20

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for DURABLE MEDICAL EQUIPMENT
Nature of License

NEVADA PRIME HEALTHCARE LLC
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

KOLER — Last Name
JARED — First Name
OLIVER — Middle Name
JERRID — Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

CASCADE STABLE DR — Present Residence Address-Street or RFD
RENO — City
NV — State/Zip

MILL ST — Present Business Address
Dates 6/2019 to Present
RENO — City
NV — State/Zip

MEDICAL EQUIPMENT SALES — Occupation
Dates 6/2017 to Present

Phone:
Residence
Business 775-375-8649

GRANTS PASS / ST JOSEPHINE / OREGON — Place of Birth (City, County, State)
Date of Birth

47 — Age
Social Security Number or ITIN
Male — Sex

BROWN — Color of Eyes
BROWN — Color of Hair
WHITE — Complexion
200 — Weight
STOCKY — Build
5'7" — Height

Scars, tattoos or distinguishing marks and/or characteristics NA

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

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial

A. **Current Marriage** 4/27/2002 (Date) Seattle / King / WA (City, County and State)

Spouse's full name (Maiden) ATHENA DEANNE TOFFRY SS# or ITIN

Date of Birth Place of Birth TACOMA, WA

Resident address CASCADE STABLE DR (Street) RENO (City) NV (State) (Zip)

Telephone: Residenc Business SAME

Spouse's employer TACTILE MEDICAL Occupation MEDICAL DEVICE SALES

Address of employer 3701 WAYZATA BLVD STE 300 (Street) MINNEAPOLIS (City) MN (State) 55416 (Zip)

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

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

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

Name	Street	City	State	Zip	Telephone

3. **FAMILY INFORMATION:**

A. **Children and Dependents**:

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

Name	Birth Date	Birth Place	Residence Address
GAGE KOLEN		WA	CASCADE STABLE DR
DARIAN KOLEN		NV	89521

B. **Child Support Information:**

Please mark the appropriate response:

- [x] 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

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

Name_____

Address_____

Contact person_____

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	LAWRENCE HOLEN		Ave NW Seattle WA	LENDING LOR
Mother	KATHERINE SCHMID		CASCADE STABLE DR RENO, NV	RETIRED
Father-in-Law				
Mother-in-Law	Catherine Lyncs		Ave NW Seattle WA	RETIRED

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	JENNIFER HOLEN		BRISBAN AUSTRALIA	BOOKKEEPER
Spouse	ANGELA HOLEN		Seattle WA	Sales
	MARTY DUNN	UNK	Seattle WA	TRUCK DRIVER
Spouse	NICOLE HOLEN		Seattle WA	NA
	JORDAN JANSOUR	UNK	Seattle WA	RESEARCH SCIENTIST
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Sanslo	Seattle WA	1980-84	Yes / No
High School	Chief Salth	Seattle WA	1986-90	Yes / No
College University	University of Nevada	Reno, NV	2003-6	Yes / No
Other	SAME		2015-19	Yes / No

Type of degree obtained, if any BS. Business Administration M.S. Biotechnology

College or university where obtained University of Nevada, Reno

Applicant's initial _____

5 MILITARY INFORMATION:

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

Branch US Army Date of entry-active service 5/5/1992

Date of separation 11/94 Type of discharge OTHER THAN HONORABLE

Rating at separation E-1 Serial numb [redacted]

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 King State WA Date registered 9-19-90

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
1-4-2000	27	POSSESSION MARIJUANA	CEDAR CITY, UT	1-4-00	SHERIFFS DEPT

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 _____

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
12/2018-Present	CASCADE STABLE DR	RENO	NV
12/16 - 12/18	150 PINEY CREEK RD	RENO	NV
6/12 - 12/16	15793 FAWN LN	RENO	NV
6/06 - 6/12	6255 W ARBY DR	LAS VEGAS	NV
6/06 - 6/08	3812 AQUA LN	POUND ROCK	TX
6/04 - 6/06	1429 LINDSAY DR	RENO	NV
6/03 - 6/04	4050 CANOCHA AVE	RENO	NV
10/00 - 6/03	#2319 N 113TH PL	Seattle	WA
6/98 - 10/00	2822 DAWN CROSSING DR	HENDERSON	NV
8/96 - 6/98	6421 W Buttary PL	Littleton	CO
1/95 - 8/96	2325 McCue RD	HOUSTON	TX

Applicant's initial JE

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
JAN/19	NEVADA PRIME HEALTHCARE LLC 3100 MILL ST Ste 2133 RENO NV 89502	PRESENT
Title	**Description of Duties**	**Name of Supervisor**
OWNER	MEDICAL DEVICES SALES	SELF

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
JUN/17	SPECTRUM HEALTHCARE LLC 20 VALLEVILLE RD ENGLEVILLE PA 19403	PRESENT
Title	**Description of Duties**	**Name of Supervisor**
Sales Manager	MEDICAL DEVICE SALES	SELF

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
JUN/2012	CHARLIE PALMER GROUP 2500 E. SECOND ST RENO NV 89595	GRADUATED - NEW JOB
Title	**Description of Duties**	**Name of Supervisor**
BARTENDER	SALES FOOD & ALCOHOL	JOSH RICHWARDT

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
MAY/2008	NO LIMIT NO PROFIT LAS VEGAS NV	MOVED TO RENO
Title	**Description of Duties**	**Name of Supervisor**
DIRECTOR	GENERAL OFFICE WORK FOR NON PROFIT	VANESSA ROSSO

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
JUN 2006	DELL COMPUTERS 1 DELL WAY AUSTIN, TX	MOVED TO VEGAS
Title	**Description of Duties**	**Name of Supervisor**
Sales	INSIDE SALES REP - COMPUTERS	MICHELLE BLAND

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
AUG 2004	RENO HILTON 2500 E SECOND ST RENO NV 89595	GRADUATED - NEW JOB
Title	**Description of Duties**	**Name of Supervisor**
WAITER	SALES - FOOD & ALCOHOL	JOHN SCOTT

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
MAY 2001	DANIEL BAILEY 809 FAIRVIEW PL SEATTLE WA 98109	MOVED TO ATTEND UNR
Title	**Description of Duties**	**Name of Supervisor**
BARTENDER	SALES FOOD & ALCOHOL	FRED GOULD

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
MAR/96	MORTONS OF CHICAGO 5000 WESTHEIMER #190 HOUSTON TX 77056	BUSINESS SLOWED - NEW JOB
Title	**Description of Duties**	**Name of Supervisor**
WAITER	SALES FOOD & ALCOHOL	JIM HOFER

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

Applicant's initial _____

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name JOHN SCOTT	Home	RENO	NV		-4282	16
Employer MONTRELUX	Business	HOSPITALITY				
Name JOHN EKEZIAN	Home	RENO	NV		-8175	8
Employer TOTAL WINE	Business	MANAGER				
Name Geoff Lay	Home	Las Vegas	NV		-0175	12
Employer Custom IT	Business	PC REPAIR				
Name JAMESON CHAN	Home	LAS VEGAS	NV		-9046	13
Employer HEALTHCARE	Business	HEALTHCARE				
Name BRIAN BELAND	Home	Walnut Creek	CA		-3483	16
Employer American Mortgage	Business	HOME LOAN CONSULTANT				

10. Do you have any safe deposit box or other such depository, access to any deposit ory or do you use any other person's depository? Yes (No)
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users

11. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes (No)
If yes, state type, where and years held

12. Have you ever applied for a city, county of state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes (No)
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

Applicant's initial JE

any reason whatsoever? Yes No

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

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

15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes No

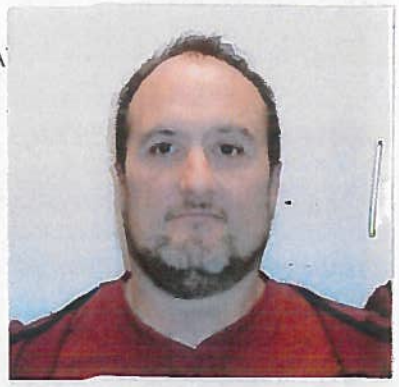
16. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes No

17. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances? Yes No

18. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a manufacturer Yes No

19. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry? Yes No

A



Date of photograph 4/21/20

Applicant's initial JE

STATE OF NEVADA
ss.
COUNTY OF WASHOE

I, JAMES OLIVER KOLOR, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a manufacturer license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

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

Original Signature of Applicant

Subscribed and Sworn to before me this 21st day of April, 2020

Notary Public

JEANNE LEIGH AHARONIAN
Notary Public - State of Nevada
County of Washoe
APPT. NO. 17-3574-2
My Appt. Expires Sept. 13, 2021

Applicant's initial

EMPLOYMENT HISTORY CONTINUED:

AUG 94 — The LAKES CLUB — MOVED TO HOUSTON
777 100TH Ave NE BELLEVUE WA
WAITER — Sales FOOD & Alcohol — Rebecca PRICE

MAY 92 — US ARMY — MENTAL HEALTH
FOOD SERVICE SPECIALIST — 1/505TH Ft Bragg NC — SSGT WALLER

JAN 90 — RED ROBIN — ENLISTED IN ARMY
17300 SOUTHCENTER PKWY
WAITER — TUKWILA, WA 98188

Applicant's initial _____

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 4-21-20

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for DME- Pneumatic Compression Device - Lymphedema

Nature of MDEG

NEVADA PRIME HEALTHCARE LLC 3100 MILL ST #213B RENO NV 89502

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

JK

1. PERSONAL INFORMATION:

KOLER — Last Name
JARED — First Name
OLIVER — Middle Name

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

CASCADE STABLE DR — Present Residence Address-Street or RFD
RENO — City
NV 89521 — State/Zip

3100 Mill St 213B — Present Business Address
Dates Aug 2019 to present
RENO — City
NV 89521 — State/Zip

OWNER — Present Position with the MDEG
Dates JAN 2019 to Present

Phone: 775-375-8649 Fax: 775-571-1860

Email address: nevadaprime.com

Date of Birth
Grants Pass, OR — Place of Birth (City, County, State)

47 — Age
Social Security Number
Male — Sex

Brown — Color of Eyes
Brown — Color of Hair
190 — Weight
5'7" — Height

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

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

JK

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

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
6/2017 to Present	SPECTRUM HEALTHCARE 20 Eagleville rd Eagleville, PA 19403	5,440
Title	**Description of Duties**	**Name of Supervisor**
Sales Manager	All Sales Duties for Pneumatic Compression Devices	Self
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

I have ☐ I have not ☒ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☒ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☒ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☒ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: _____

b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☒ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☒ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☒ No ☐

If you answer No to questions 4, 5 or 6 please provide a written

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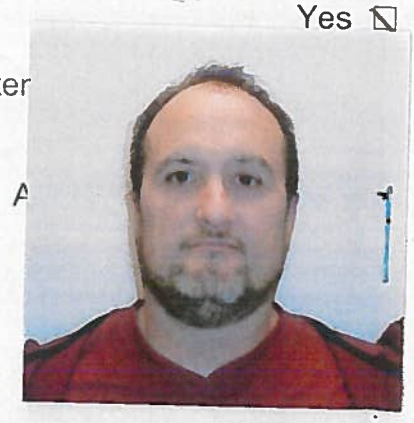

Date of photograph 4-21-20

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

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

Original Signature of Applicant