

24

PH04217

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206– Reno, NV 89521 – (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: off-site Rampart PharmacyPhysical Address: 1000 Fairgrounds RdCity: WINNEMUCCA, NVState: Zip Code: 89445

Telephone: _____

775-623-5222 R&Ext 1551Fax: 775-625-8559Toll Free Number: N/AE-mail: hghrx@hghospital.orgWebsite: N/AManaging Pharmacist: Cody BrightLicense Number: 18027**TYPE OF PHARMACY AND****SERVICES PROVIDED**

Yes/No

☐ ☒ Retail☒ ☐ Hospital (# beds 44)☐ ☒ Internet☐ ☒ Nuclear☐ ☒ Ambulatory Surgery Center☐ ☒ Community☐ ☒ Other: See comment below

All boxes must be checked

For the application to be complete

Yes/No

☒ ☐ Off-site Cognitive Services☒ ☐ Parenteral -Immediate Use Only☐ ☒ Parenteral (outpatient)☐ ☒ Outpatient/Discharge☐ ☒ Mail Service☐ ☒ Long Term Care☐ ☒ Sterile Compounding☐ ☒ Non Sterile Compounding☐ ☒ Mail Service Sterile Compounding☐ ☒ Other Services: See comment belowThis is an EOC off-site Emergency use only designated pharmacy

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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.

David Simsek

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

DAVID SIMSEK

Print Name of Authorized Person

04-15-2020

Date

Board Use Only

Date Processed: _____

Amount: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: Humboldt County Hospital District
 Business Name: Humboldt General Hospital
 Current Business Address: 118 East Haskell St
 City: WINNEMUCCA State: NV Zip Code: 89445
 Telephone: 775-623-5222 Ext 1551 Fax: 775-625-8559

List any physician shareholders and percentage of ownership.

Name: N/A %: _____
 Name: _____ %: _____
 Name: _____ %: _____
 Name: _____ %: _____

Hours of Operation for the pharmacy:

☒ ON CALL

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: N/A

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

I, Karen Cole

Responsible Person of Humboldt General Hospital

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.

Karen S. Cole

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

Karen S. Cole

Print Name of Authorized Person

4/19/2020

Date

Managing Pharmacist

 Pharmacist Name: Cody Bright

 License #: 18027

 Pharmacy Name: off-Site RAMPART 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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

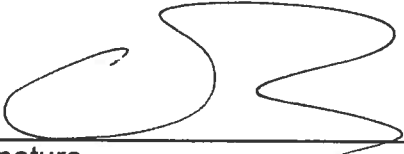
If you marked YES to any of the numbered questions above, please include the following information

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

PHARMACY MANAGER'S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)
2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)
3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)
4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)
5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)
6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)
7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)
8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)
9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.



Signature

4 15 20

Date