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27A

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy, Suite 206 – Reno, NV 89521 – (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 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☒ 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: AMG Medical Supplies LLC

Physical Address: 1840 E. Calvada Blvd ste 9 Pahrump, NV 89048

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 4325 Dean Martin Drive ste 340

City: Las Vegas State: NV Zip Code: 89130

Telephone: 702-908-5274 Fax: _____

E-mail: amadordonald86@gmail.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5PM Tue: 9am to 5PM Wed: 9am to 5pM Thu: 9am to 3pM

Fri: 9am to 5PM Sat: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Christina Danielle Guerrero

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: Incontinence

**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: _____

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:

Donald Amador	Medicare & Medicaid pending	

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.

☐ Practitioner	Name: none
☐ 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.

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.

X _____

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

Donald Amador

Print Name of Authorized Person

11/4/19

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: Donald Amador

Business Name: AMG Medical Supplies LLC

Current Business Address: 1840 E. Calvada Blvd Ste 9

City: Pahrump State: NV Zip: 89048

Telephone: 702-908-3274 Fax:

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*.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/22/2019

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 CS&S/KRAFT LAKE INSURANCE AGCY INC PO BOX 958489 LAKE MARY, FL 32746-8989 Phone - 877-724-2669 Fax - 877-763-5122	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Continental Casualty Company — 20443
INSURED AMG MEDICALGROUP 1840 E CALVADA BLVD STE 9 PAHRUMP Nevada 89048	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	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER ☐ POLICY ☐ PRO-JECT ☒ LOC ☐ OTHER	N	N	6025283028	07/11/2019	07/11/2020	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 300,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ 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 ANY PROPRIETOR/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)

*********Proof of Insurance*********

CERTIFICATE HOLDER	CANCELLATION
AMG MEDICALGROUP 1840 E CALVADA BLVD STE 9 PAHRUMP Nevada 89048	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 Kyra M'Connaughey

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 01/27/2020

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 Administrator

AMG Medical Supply — Nature of MDEG — 1840 E Calvada Blvd #9, Pahrump, NV 89048

Name and Address of Business for Which MDEG Administrator Is Requested

AMG

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

McBride (Last Name) | Steven (First Name) | Anthony (Middle Name)

N/A
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Olvera Way (Present Residence Address-Street or RFD) | Las Vegas, NV 89128 (City, State/Zip)

1840 E Calvada Blvd #9 (Present Business Address) | Dates 01/11/2019 – Present | Pahrump, NV 89048 (City, State/Zip)

Business Development (Present Position with the MDEG) | Dates 01/11/2019 – present

Phone: | Fax: N/A

Email address: N/A

Date of Birth | Van Nuys, Los Angeles, CA (Place of Birth (City, County, State))

33 (Age) | Social Security Number | Male (Sex)

Brown (Color of Eyes) | Brown (Color of Hair) | 180 lbs (Weight) | 5'5" (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 N/A

If naturalized, certificate No N/A Date N/A

Place N/A (If naturalized, document must be verified.)

EMPLOYMENT:

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
02/2017	Amador Medical LLC 4525 Dean Martin Dr. #740	40/wk (4,990)
Title	**Description of Duties**	**Name of Supervisor**
Business Development, Customer Service		Donald Amador
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

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 ☐ 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:
b)

State: N/A

Date: N/A

Case Number: N/A

c) Criminal Action:

State: Nevada

Date: 03/08/2018

Case Number: C1189026A

County: Clark

Court: Municipal

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 letter of explanation.

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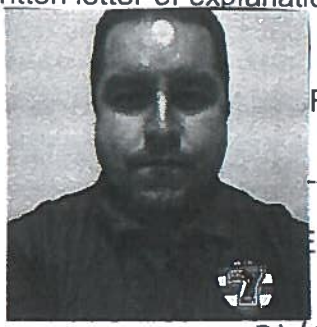

RAPH

AST

Date of photograph 01/28/2020

I, Steven McBride, 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

Written Explanation for page 4, question 1 on the Board of Pharmacy Application To Be The MDEG Administrator for AMG, LLC

Attention Board Members of the Nevada State Board of Pharmacy,

My name is Steven Anthony McBride and I am writing this letter as an explanation of my misdemeanor crime committed on 03/08/2018, a subsequent conviction of driving under the influence.

After having exited a failed relationship at the end of 2016, I began to drink alcohol more often than usual and this caught up with me in March of 2017 when I was arrested for a first DUI. This helped me to see that drinking was a problem, however the following March of 2018 after having a few drinks after work, I received another DUI.

I have since had no problems with alcohol and driving, and I intend to keep it that way, as I know that the work we do is important to the health and safety of others in receiving there medical equipment and supplies. If I consume any alcohol outside of home, I utilize ride sharing companies like Uber and Lyft as this is the only sane and proper solution.

I do hope that these revelations do not bar me from becoming the Administrator for the new office we are opening, and I ask that you please consider that I love my work very much and really look forward to taking it to the next step.

.....

Original Signature of Applicant

27B

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy, Suite 206 – Reno, NV 89521 – (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 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☑ 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: Pop Durable Medical Equipment

Physical Address: 501 S. Rancho Dr. # I -58

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 526 S. Tonopah Dr. #120 Las Vegas, NV 89106

City: Las Vegas State: NV Zip Code: 89106

Telephone: 702-243-7671 Fax: _____

E-mail: jimmy@popprosthetics.com Website: www.popprosthetics.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 to 5 Tue: 8 to 5 Wed: 8 to 5 Thu: 8 to 5

Fri: 8 to 5 Sat: 0 to 0 Sun: 0 to 0 Holidays: 0 to 0

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Megan Weide

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: Wheel Chairs

**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: Jimmy Colson Telephone: 702 743-5179

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:

5503020002	1005093141	
5503020001		

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.

☑ 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.

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.

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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.

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

Jimmy Adam

Print Name of Authorized Person

1/9/2020

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: Jimmy Colson

Business Name: Pop Durable Medical Equipment

Current Business Address: 501 S. Rancho Dr. # I -58

City: Las Vegas State: NV Zip: 89106

Telephone: 702-243-7671 Fax: 702-259-7671

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*.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 1/9/20

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.

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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 Administrator
Nature of MDEG

POP Durable medical Equipment 501 S. Rancho Suite I-58
Name and Address of Business for Which MDEG Administrator Is Requested Las Vegas, NV 89104

~~If applicable, Name Under Which It Is Now Operated~~

1. PERSONAL INFORMATION:

Weide (Last Name) megan (First Name) Jane (Middle Name)

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

[redacted] Laurelwood Ave Las Vegas, NV 89122
Present Residence Address-Street or RFD City State/Zip

501 S. Rancho Suite I-58 Las Vegas, NV 89106 Dates
Present Business Address City State/Zip

office manager Dates
Present Position with the MDEG

Phone: [redacted] Fax: (702)259-7671

Email address: megan@poppprosthetics.com

[redacted] Placerville, CA
Date of Birth Place of Birth (City, County, State)

36 [redacted] F
Age Social Security Number Sex

Green Blonde 125 5'3
Color of Eyes Color of Hair Weight Height

Scars, tattoos or distinguishing marks and/or characteristics _____

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.)

EMPLOYMENT:

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
September 2012 - current	POP Prosthetics	40 hours per week
Title	**Description of Duties**	**Name of Supervisor**
office manager -	over see office/employees	Sara colson
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: NV

Date: 2007

Case Number: Unknown

County: Clark

Court: Justice

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 letter of explanation.

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I, Megan Jane Weide, 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.

Megan Jane Weide

Original Signature of Applicant

WELLS FARGO

Jurat Certificate

State of Nevada

County of Clark

Subscribed and sworn to (or affirmed) before me on this Jan

day of 9th, 2020, by Megan J Weibe

Place Seal Here

JAVIER CURIEL
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 05-23-2022
Certificate No: 18-2800-1

Notary Signature

Description of Attached Document

Type or Title of Document: Application to be the MDEG Administrata

Document Date: 1-9-2020

Number of Pages: 5 pages

Signer(s) Other Than Named Above: None

DSG3018 (Rev 00-2-15)

BUSINESS LICENSE*

City of Las Vegas - Las Vegas, Nevada

IN ACCORDANCE WITH THE PROVISIONS OF THE LAS VEGAS MUNICIPAL CODE, AS AMENDED, LICENSE IS HEREBY GRANTED TO OPERATE THE BUSINESS REFERENCED BELOW.

LICENSE #: G68-00193

RENEWAL DATE: 1/24/2020

EXPIRE DATE: 7/1/2020

TYPE OF LICENSE: G50 - General Retail Sales
Durable Medical Equipment Sales

BUSINESS LOCATION: 501 S Rancho Dr I58

ISSUED TO:

PRECISION ORTHOTICS & PROSTHET
526 S TONOPAH DR 120
Las Vegas, NV 89106

Mary C McElhern

Deputy Director, Planning Department

Failure to maintain an active state license or a SNHD health permit, if required, renders this business license invalid.

Post in a conspicuous place.

PREC009 OP ID: HZ

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/30/2020

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 800-544-2672 Affinity Insurance Services 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034 Affinity Insurance Services	CONTACT NAME: PHONE (A/C, No, Ext): 800-544-2672 FAX (A/C, No): 847-953-4779 E-MAIL ADDRESS:
INSURED Precision Orthotics & Prosthetics LLC dba POP Prosthetics Pop Durable Medical Equipment 526 S. Tonopah Dr #120 Las Vegas, NV 89106	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : CNA- Valley Forge Insurance Co INSURER B : CNA - Columbia Casualty 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						EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE X OCCUR			6024920453	08/20/2019	08/20/2020	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	POLICY PRO-JECT X LOC						PRODUCTS - COMP/OP AGG	$ 4,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N/A						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
B	Professional Liab.			658730101	08/20/2019	08/20/2020	Per Claim	1,000,000
							Aggregate	3,000,000

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

Locations
526 S Tonophan Drive Ste 120 Las Vegas, NV 89106
8915 S Pecos Rd Ste 18A Henderson, NV 89074
7350 W Cheyenne Ave Las Vegas, NV 89129

CERTIFICATE HOLDER

FYIO001

FOR INFORMATION PURPOSES ONLY

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
Affinity Insurance Services

ACORD 25 (2016/03)