4

4A

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*** PH03716 + name change

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: AFA Pharmacy, LLC

Physical Address: 8360 Lyndon B Johnson Freeway, Suite A215, Dallas, TX 75243-1130

Mailing Address: 8360 Lyndon B Johnson Freeway, Suite A215,

City: Dallas State: TX Zip Code: 75243-1130

Telephone: (346) 224-2125 Fax: (888) 234-7319

Toll Free Number: (844) 732-3280 ✓ (Required per NAC 639.708)

E-mail: compliance@afapharmacy.com Website: www.afapharmacy.com

Managing Pharmacist: Jenner Uy Sinang License Number: 46863

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.

Justin A. Stone

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

Justin A. Stone, Secretary

Print Name of Authorized Person

12/01/19

Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: TM Pharma Holdings, LLC

Mailing Address: 29 West 30th Street, 4th Floor

City: New York State: NY Zip: 10001

Telephone: (361) 563-4978 Fax: N/A

Contact Person: Justin A. Stone, Secretary

For any corporation non publicly traded, disclose the following:

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

a) TM Pharma Holdings, LLC (Name) — 100% Direct Owner / Sole Member — 29 West 30th Street, 4th Floor New York, NY 10001 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. N/A - entitiy is a LLC

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

4) What date did the corporation actually receive the cash assets? 11/29/2019

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

List any physician shareholders and percentage of ownership.

Name: N/A - none %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday	900 am	530 pm	Saturday	closed am	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: 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

Steven C. Gutentag, CEO
Demetrius M. Karagas, President and Treasurer
Justin A. Stone, Secretary

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Justin A. Stone

Responsible Person of AFA Pharmacy, LLC

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

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

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

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

Justin A. Stone

Print Name of Authorized Person

12/01/19

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Texas)
) ss.
Dallas COUNTY)

I, Justin A. Stone, 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 Secretary for AFA Pharmacy, 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, Justin A. Stone, 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
22nd day of November, 2019.

NOTARY PUBLIC

JESSICA RIGGS
Notary Public, State of Texas
Comm. Expires 04-05-2022
Notary ID 13152122-7

Change of Ownership Documents

BILL OF SALE

This BILL OF SALE (this "Bill of Sale") is made effective and delivered as of December 5, 2019, by Executive Enterprises, LLC, a Texas limited liability company dba The Woodlands Apothecary (the "Seller"), to AFA Pharmacy, LLC, a Delaware limited liability company ("Buyer"). All capitalized terms used in this Bill of Sale without definition have the meanings given to them in the Purchase Agreement (as defined below).

WHEREAS, Seller and Buyer are parties to that certain Asset Purchase Agreement, dated as of December 5, 2019 (the "Purchase Agreement"), pursuant to which Seller agreed to sell, and Buyer agreed to buy, the Purchased Assets; and

WHEREAS, Seller desires to effectuate the sale, assignment, conveyance, transfer and delivery to Buyer of the Purchased Assets.

NOW, THEREFORE, in consideration of the foregoing premises and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Seller hereby agrees as follows:

1. Sale and Transfer of the Purchased Assets. Seller hereby sells, assigns, conveys, transfers and delivers to Buyer all of Seller's right, title and interest, legal and equitable, in, under, and to the Purchased Assets. The Seller's drug inventory and patient records are not included in the Purchased Assets. Seller will retain possession and control of the Seller's existing drug inventory and any patient records as of the purchase date and will remove the drug inventory and patient records along with any patient information from the Purchased Assets on the purchase date.

2. Governing Agreement. This Bill of Sale is expressly made subject to the terms and provisions of the Purchase Agreement. The delivery of this Bill of Sale shall not affect, enlarge, diminish, or otherwise impair any of the representations, warranties, covenants, conditions, indemnities, terms, or provisions of the Purchase Agreement, and all of the representations, warranties, covenants, conditions, indemnities, terms, and provisions contained in the Purchase Agreement shall survive the delivery of this Bill of Sale to the extent, and in the manner, set forth in the Purchase Agreement. In the event of a conflict between the terms and provisions of this Bill of Sale and the terms and provisions of the Purchase Agreement, the terms and provisions of the Purchase Agreement shall govern and control.

3. Further Assurances. Seller hereby covenants and agrees that, at any time after the date hereof, Seller will execute and deliver all such other and further instruments of assignment or transfer as may be reasonably requested by the Buyer, from time to time, to effect, evidence and complete the aforesaid sale and transfer of the Purchased Assets to the Buyer as required or contemplated under the Purchase Agreement.

4. Governing Law. This Bill of Sale shall be governed by and construed in accordance with the internal laws of the State of Delaware without giving effect to any choice or conflict of law provision or rule (whether of the State of Delaware or any other jurisdiction).

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned have executed this Bill of Sale as of the date first set forth above.

EXECUTIVE ENTERPRISES, LLC

dba The Woodlands Apothecary

By: Michael Burch

Name: Mike Burch

Title: President

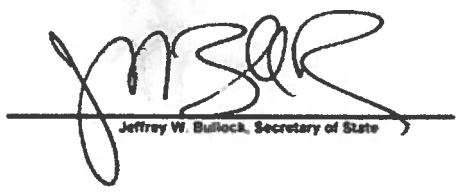
Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "AFA PHARMACY, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-FIRST DAY OF NOVEMBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.





7703529 8300

SR# 20198237810

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 204063614

Date: 11-21-19

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "AFA PHARMACY, LLC", FILED IN THIS OFFICE ON THE FOURTEENTH DAY OF NOVEMBER, A.D. 2019, AT 1:29 O`CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

7703529 8100
SR# 20198084077

Authentication: 204005780
Date: 11-14-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 01:29 PM 11/14/2019
FILED 01:29 PM 11/14/2019
SR 20198084077 - File Number 7703529

CERTIFICATE OF FORMATION
OF
AFA PHARMACY, LLC

This Certificate of Formation of AFA Pharmacy, LLC (the "*Company*") is being filed by the undersigned authorized person to form a limited liability company under the Delaware Limited Liability Company Act, *6 Del. C.* Section 18-101 *et seq.* (the "*Act*").

FIRST: The name of the limited liability company is AFA Pharmacy, LLC.

SECOND: The address of the limited liability company's registered office in the State of Delaware and the name of its registered agent for service of process at such address are:

United Corporate Services, Inc.
874 Walker Road, Suite C
Dover, Delaware 19904

THIRD: The limited liability company is formed effective as of the filing of this Certificate of Formation and shall be authorized to carry on any lawful business for which a limited liability company may be organized under the Act.

IN WITNESS WHEREOF, the undersigned authorized person has executed this CERTIFICATE OF FORMATION in accordance with Section 18-204 of the Act.

By: /s/ Justin Stone
Name: Justin Stone
Title: Authorized Person

4B

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

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: Chewy Pharmacy, LLC

Physical Address: 11403 Bluegrass Parkway, Suite 650, Jeffersontown, KY 40299

Mailing Address: 11403 Bluegrass Parkway, Suite 650

City: Jeffersontown State: KY Zip Code: 40299

Telephone: 786-320-7111, Ext. 63829 Fax: 866-253-0274

Toll Free Number: 877-977-3879 ✓ (Required per NAC 639.708)

E-mail: SDF4@chewy.com Website: www.chewy.pharmacy

Managing Pharmacist: Leah Davis License Number: 015025

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: Veterinary	☐	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 ☒

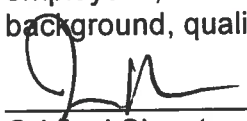
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Justin Mills

Print Name of Authorized Person

11-15-19

Date

Board Use Only Date Processed: _____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Chewy, Inc. - Sole Member

Corporation Name: Chewy Pharmacy, LLC

Mailing Address: 11403 Bluegrass Parkway, Suite 650

City: Jeffersontown State: KY Zip: 40299

Telephone: 786-320-7111, Ext. 63829 Fax: 866-253-0274

Contact Person: Leah Davis, PIC

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: Chewy, Inc. became publicly traded on 06/14/2019

Registration number issued: 0001766502

Stock Exchange: CHWY

Hours of Operation for the pharmacy:

Monday thru Friday _____am _____pm Saturday _____am _____pm

Sunday _____am _____pm 24 Hours x

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

Must be included with the application for a 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. - See attached

List of officers and directors. - See attached

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Justin Mills

Responsible Person of Chewy Pharmacy, LLC

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

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

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

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

Justin Mills
Print Name of Authorized Person

11-15-19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF _____)
) ss.
_____COUNTY)

I, Justin Mills, 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 Vice President for Chewy Pharmacy, 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, Justin Mills, 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
15 day of Nov, 2019.

NOTARY PUBLIC

TEJAL SHAH
NOTARY PUBLIC
STATE AT LARGE
KENTUCKY

Nevada - Chewy Pharmacy, LLC - Jeffersontown

Chewy Pharmacy, LLC - Officer List
Justin Mills, Vice President
Aseemita Malhotra, President

Chewy, Inc. - Officer List
Sumit Singh, CEO
Mario Marte, CFO
Susan Helfrick, CLO
Satish Mehta, CTO

Kentucky Board of Pharmacy

License Verification Details

Detail for License Number P08055

CHEWY PHARMACY LLC

11403 BLUEGRASS PARKWAY
STE 650
JEFFERSONTOWN, KY 40299

Kentucky Board of Pharmacy

State Office Building Annex, Ste 300
125 Holmes Street
Frankfort, KY 40601

License Information

Expiration Date	6/30/2020
Effective Date	4/30/2019
Status of Permit	Active
Board Action	No
Case Number(s)	

The Kentucky Board of Pharmacy website is considered primary source verification and is actually the preferred method of licensure verification. Both JCAHO and the Cabinet for Health and Family Services, Office of the Inspector General, consider verification through the website as evidence of licensure.

COMMONWEALTH OF KENTUCKY

KENTUCKY BOARD OF PHARMACY

State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601

LICENSE/PERMIT: Resident Pharmacy

EFFECTIVE DATE: 04/30/2019

NUMBER: P08055

EXPIRATION DATE: 06/30/2020

PIC: LEAH ELISE DAVIS

Issued to:
CHEWY PHARMACY LLC

11403 BLUEGRASS PARKWAY
STE 650
JEFFERSONTOWN, KY 40299

License/Permit must be posted in public view.

The official status of this license/permit can be verified at www.pharmacy.ky.gov.

The facility above is hereby licensed or permitted at the above address, and is subject to the rules and regulations of the Kentucky Board of Pharmacy.

christine.cassetta@quarles.com

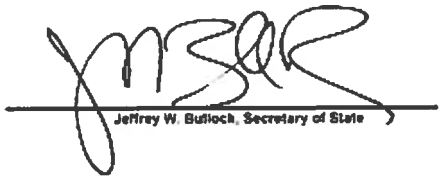
Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "CHEWY PHARMACY, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FIFTH DAY OF NOVEMBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.





6981831 8300

SR# 20197917632

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 203937058

Date: 11-05-19

4C

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: Costco Pharmacy #1347

Physical Address: 260 Logistics Ave., Suite C, Jeffersonville, IN 47130-4672

Mailing Address: Attn: Licensing, PO Box 35005

City: Seattle State: WA Zip Code: 98124-3405

Telephone: 425-313-8219 Fax: 425-313-6922

Toll Free Number: 800-607-6861 (Required per NAC 639.708)

E-mail: ksheare@costco.com Website: www.costco.com

Managing Pharmacist: Travis Cunningham License Number: 26026276A

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: Central Fill	☐	☑ 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

Victor Curtis
Print Name of Authorized Person

11/12/19
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PUBLICY TRADED CORPORATION

State of Incorporation: Washington

Parent Company if any: N/A

Corporation Name: Costco Wholesale Corporation

Mailing Address: Attn: Licensing, PO Box 35005

City: Seattle State: WA Zip: 98124-3405

Telephone: 425-313-8219 Fax: 425-313-6922

Contact Person: Kristopher Shearer

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: 5/12/1987

Registration number issued: C4347-1987

Stock Exchange: NASDAQ

Hours of Operation for the pharmacy:

Monday thru Friday	5:00 am	7:00 pm	Saturday	9:30 am	2:00 pm
Sunday	Closed am	pm	24 Hours	N/A	

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

Must be included with the application for a 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.

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Victor Curtis

Responsible Person of Costco Pharmacy #1347

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

Victor Curtis
Print Name of Authorized Person

11/12/19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Kentucky)
) ss.
Jefferson COUNTY)

I, Travis Cunningham, 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 Pharmacist In Charge for Costco #1347 (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, Travis Cunningham, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name Travis Cunningham

SUBSCRIBED AND SWORN TO
before me, a notary public this
6th day of November, 2019.

NOTARY PUBLIC

Theodore Robinson
Notary Public, ID No. 566318
State at Large, Kentucky
My Commission Expires on October 6, 2020

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF EXISTENCE

OF

COSTCO WHOLESALE CORPORATION

I CERTIFY that the records on file in this office show that the above named entity was formed under the laws of the State of Washington and that its public organic record was filed in Washington and became effective on 05/12/1987.

I FURTHER CERTIFY that the entity's duration is Perpetual, and that as of the date of this certificate, the records of the Secretary of State do not reflect that this entity has been dissolved.

I FURTHER CERTIFY that all fees, interest, and penalties owed and collected through the Secretary of State have been paid.

I FURTHER CERTIFY that the most recent annual report has been delivered to the Secretary of State for filing and that proceedings for administrative dissolution are not pending.

Issued Date: 11/01/2019
UBI Number: 601 024 674

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Kim Wyman

Kim Wyman, Secretary of State

Date Issued: 11/01/2019

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FC8687278	08-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3 3N,4,5	CENTRAL FILL PHARMACY	08-19-2019

COSTCO WHOLESALE CORPORATION
DBA COSTCO PHARMACY #1347
260 LOGISTICS AVE
SUITE C
JEFFERSONVILLE, IN 47130

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FC8687278	08-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3 3N,4,5	CENTRAL FILL PHARMACY	08-19-2019

COSTCO WHOLESALE CORPORATION
DBA COSTCO PHARMACY #1347
260 LOGISTICS AVE
SUITE C
JEFFERSONVILLE, IN 47130

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

COSTCO WHOLESALE CORPORATION
PRINCIPAL OFFICERS AND DIRECTORS

Title	First	Last
President/CEO/ Director	Walter	Jelinek
Exec VP/CFO/ Director	Richard	Galanti
Exec VP/Assistant Secretary	Patrick	Callans
Senior VP	Victor	Curtis
Senior VP/Secretary	John	Sullivan
VP/Treasurer	Jeffrey	Elliott
AVP/Assistant Secretary	Margaret	McCulla
AVP/Assistant Secretary	Gail	Tsuboi
Director	Susan	Decker
Director	Kenneth	Denman
Director	Hamilton	James
Director	John	Meisenbach
Director	Charles	Munger
Director	Jeffrey	Raikes
Director	John	Stanton
Director	Maggie	Wilderotter

Indiana Professional Licensing Agency
Indiana Board of Pharmacy
402 W. Washington Street, W072
Indianapolis, IN 46204

Pharmacy

License Number	Expire Date
60006740A	12/31/2021

Costco Wholesale Corporation d/b/a Costco Pharmacy #1347

Eric J. Holcomb
Governor
State of Indiana

Deborah J. Frye
Executive Director
Indiana Professional Licensing Agency

Indiana Professional Licensing Agency
402 W. Washington Street, W072
Indianapolis, IN 46204

Pharmacy

License Number	Expire Date
60006740A	**12/31/2021**

Costco Wholesale Corporation d/b/a Costco Pharmacy #1347

Signature

4D

18

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: Costco Pharmacy #1349

Physical Address: 260 Logistics Ave., Suite A, Jeffersonville, IN 47130-4672

Mailing Address: Attn: Licensing, PO Box 35005

City: Seattle State: WA Zip Code: 98124-3405

Telephone: 425-313-8219 Fax: 425-313-6922

Toll Free Number: 800-607-6861 ✓ (Required per NAC 639.708)

E-mail: ksheare@costco.com Website: www.costco.com

Managing Pharmacist: Michael Gorski License Number: 26019570A

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: Mail Order	☐	☑ 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

Victor Curtis
Print Name of Authorized Person

11/01/19
Date

Board Use Only Date Processed:_____ Amount: _____

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PUBLICY TRADED CORPORATION

State of Incorporation: Washington

Parent Company if any: N/A

Corporation Name: Costco Wholesale Corporation

Mailing Address: Attn: Licensing, PO Box 35005

City: Seattle State: WA Zip: 98124-3405

Telephone: 425-313-8219 Fax: 425-313-6922

Contact Person: Kristopher Shearer

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: 5/12/1987

Registration number issued: C4347-1987

Stock Exchange: NASDAQ

Hours of Operation for the pharmacy:

Monday thru Friday	5:00 am	7:00 pm	Saturday	9:30 am	2:00 pm
Sunday	Closed am	pm	24 Hours	N/A	

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

Must be included with the application for a 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.

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Victor Curtis

Responsible Person of Costco Pharmacy #1349

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

Victor Curtis
Print Name of Authorized Person

11/01/19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF INDIANA)
) ss.
CLARK COUNTY)

I, Michael Gorski, 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 Pharmacist-In-Charge for Costco Pharmacy #1349 (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, Michael Gorski, 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
28th day of October, 2020.

Janice M. Savino
NOTARY PUBLIC

JANICE M SAVINO
Official Seal
Notary Public - State of Illinois
My Commission Expires Jan 3, 2023

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF EXISTENCE

OF

COSTCO WHOLESALE CORPORATION

I CERTIFY that the records on file in this office show that the above named entity was formed under the laws of the State of Washington and that its public organic record was filed in Washington and became effective on 05/12/1987.

I FURTHER CERTIFY that the entity's duration is Perpetual, and that as of the date of this certificate, the records of the Secretary of State do not reflect that this entity has been dissolved.

I FURTHER CERTIFY that all fees, interest, and penalties owed and collected through the Secretary of State have been paid.

I FURTHER CERTIFY that the most recent annual report has been delivered to the Secretary of State for filing and that proceedings for administrative dissolution are not pending.

Issued Date: 11/01/2019
UBI Number: 601 024 674

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Kim Wyman

Kim Wyman, Secretary of State

Date Issued: 11/01/2019

Indiana Professional Licensing Agency
Indiana Board of Pharmacy
402 W. Washington Street, W072
Indianapolis, IN 46204

Pharmacy

License Number	Expire Date
60006732A	12/31/2021

Costco Wholesale Corporation d/b/a Costco Pharmacy #1349

Eric J. Holcomb
Governor
State of Indiana

Deborah J. Frye
Executive Director
Indiana Professional Licensing Agency

Indiana Professional Licensing Agency
402 W. Washington Street, W072
Indianapolis, IN 46204

Pharmacy

License Number	Expire Date
60006732A	**12/31/2021**

Costco Wholesale Corporation d/b/a Costco Pharmacy #1349

Signature

COSTCO WHOLESALE CORPORATION
PRINCIPAL OFFICERS AND DIRECTORS

Title	First	Last
President/CEO/ Director	Walter	Jelinek
Exec VP/CFO/ Director	Richard	Galanti
Exec VP/Assistant Secretary	Patrick	Callans
Senior VP	Victor	Curtis
Senior VP/Secretary	John	Sullivan
VP/Treasurer	Jeffrey	Elliott
AVP/Assistant Secretary	Margaret	McCulla
AVP/Assistant Secretary	Gail	Tsuboi
Director	Susan	Decker
Director	Kenneth	Denman
Director	Hamilton	James
Director	John	Meisenbach
Director	Charles	Munger
Director	Jeffrey	Raikes
Director	John	Stanton
Director	Maggie	Wilderotter

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FC8494611	08-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3 3N,4,5	RETAIL PHARMACY	06-27-2019

COSTCO PHARMACY #1349
260 LOGISTICS AVE STE A
JEFFERSONVILLE, IN 47130 0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D C 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FC8494611	08-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3 3N,4,5	RETAIL PHARMACY	06-27-2019

COSTCO PHARMACY #1349
260 LOGISTICS AVE STE A
JEFFERSONVILLE, IN 47130 0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

4E

11-12

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: CURA PHARMACY

Physical Address: 17400 IRVINE BLVD, STEP, TUSTIN CA 92780

Mailing Address: SAME

City: TUSTIN State: CA Zip Code: 92780

Telephone: 714-505-2872 Fax: 714-505-2812

Toll Free Number: 844 458 0560 ✓ (Required per NAC 639.708)

E-mail: HUONGDL@HOTMAIL.COM Website: CURARX.COM

Managing Pharmacist: JUSTINA HII License Number: RPH 67558

TYPE OF PHARMACY AND SERVICES PROVIDED

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

****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

LUU, NGUYEN-HUONG

Print Name of Authorized Person

10/24/19

Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: CALIFORNIA

Parent Company if any: _____

Mailing Address: 17400 IRVINE BLVD, STE P, TUSTIN, CA 92780

City: TUSTIN State: CA Zip: 92780

Telephone: 714 505 2872 Fax: 714 505 2812

Contact Person: (Ms) HUONG

For any corporation non publicly traded, disclose the following:

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

a) HUONG LUU 17400 IRVINE BLVD, STE P, TUSTIN, CA 92780
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 1,000,000

3) What was the price paid per share? $ 0.001

4) What date did the corporation actually receive the cash assets? 10/28/2010

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

List any physician shareholders and percentage of ownership. NONE

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 8:30 pm Saturday 9 am 1 pm

Sunday N/A am _____ pm 24 Hours N/A

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, NGUYEN- HUONG D. LUU

Responsible Person of CURA PHARMACY (DBA)

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

NGUYEN- HUONG D.LUU

Print Name of Authorized Person

10/24/19

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF CALIFORNIA)
ORANGE COUNTY) ss.

I, NGUYEN - HUONG LUU, 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 PHARMACIST for CUZA PHARMACY (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, NGUYEN - HUONG LUU 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
___day of_____, 20___.

NOTARY PUBLIC

BERNADETTE LAZZARA
Notary Public – California
Orange County
Commission # 2208038
My Comm. Expires Aug 17, 2021

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California, County of Orange
Subscribed and sworn to (or affirmed) before me
on this 24th day of October, 20 19,
by Nguyen-Huong Luu,
proved to me on the basis of satisfactory evidence
to be the person(s) who appeared before me.

Signature:

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Board of Pharmacy

ORIGINAL CERTIFICATE

Retail Pharmacy Permit

LICENSE NO. PHY 50604

ISSUE DATE AUGUST 04, 2011

CURA PHARMACY

17400 IRVINE BLVD STE P
TUSTIN CA 92780

The above is licensed with the State Board of Pharmacy as a Corporation.

CORPORATION
JUSTINA SHIRLEY HII

PHARMACIST IN CHARGE

The official status of this license can be verified at www.pharmacy.ca.gov

PLACE RENEWAL LICENSE HERE

VALID UNTIL AUGUST 01, 2020

RECEIPT NUMBER 91630900

This original license must be kept for the life of the license and posted in public view.

In accordance with the provisions of Chapter 9 of Division 2 of the Business and Professions Code, the business named above is hereby licensed at the above address, and is subject to the rules and regulations of the California State Board of Pharmacy.

This permit is non transferable. Contact the California State Board of Pharmacy when there is change of ownership, location, corporate officer, director, shareholder (more than 10 percent share change), administrator or pharmacist-in-charge.

CALIFORNIA STATE BOARD OF PHARMACY
1625 NORTH MARKET BLVD., SUITE N-219
SACRAMENTO, CA 95834
(916) 574-7900

/30/19
/30/19

----- POST IN PUBLIC VIEW -----

OPHPY1 02/29/08

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FC2785395	08-31-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	RETAIL PHARMACY	07-07-2017

CURA PHARMACY
17400 IRVINE BLVD
SUITE P
TUSTIN, CA 92780-0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

[redacted]

State of California
Secretary of State

STATEMENT OF INFORMATION
(Domestic Stock and Agricultural Cooperative Corporations)

FEES (Filing and Disclosure): $25.00. If amendment, see instructions.

IMPORTANT — READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

This Space For Filing Use Only

1. CORPORATE NAME (Please do not alter if name is preprinted.) C 3326833 — S

HUONG LUU, PHARMD, INC.

DUE DATE: 10/31/2012

COMPLETE ADDRESSES FOR THE FOLLOWING (Do not abbreviate the name of the city. Items 2 and 3 cannot be P.O. Boxes.)

		CITY	STATE	ZIP CODE
2. STREET ADDRESS OF PRINCIPAL EXECUTIVE OFFICE	17400 IRVINE BLVD, SUITE P,	TUSTIN	CA	92780
3. STREET ADDRESS OF PRINCIPAL BUSINESS OFFICE IN CALIFORNIA, IF ANY		CITY	STATE	ZIP CODE
			CA	
4. MAILING ADDRESS OF THE CORPORATION, IF DIFFERENT THAN ITEM 2		CITY	STATE	ZIP CODE

NAMES AND COMPLETE ADDRESSES OF THE FOLLOWING OFFICERS (The corporation must have these three officers. A comparable title for the specific officer may be added; however, the preprinted titles on this form must not be altered.)

	ADDRESS	CITY	STATE	ZIP CODE
5. CHIEF EXECUTIVE OFFICER/ NGUYEN HUONG LUU	KEEL DR	CORONA DEL MAR	CA	92625
6. SECRETARY/ NGUYEN HUONG LUU	KEEL DR	CORONA DEL MAR	CA	92625
7. CHIEF FINANCIAL OFFICER/ NGUYEN HUONG LUU	KEEL DR	CORONA DEL MAR	CA	92625

NAMES AND COMPLETE ADDRESSES OF ALL DIRECTORS, INCLUDING DIRECTORS WHO ARE ALSO OFFICERS (The corporation must have at least one director. Attach additional pages, if necessary.)

	ADDRESS	CITY	STATE	ZIP CODE
8. NAME NGUYEN HUONG LUU	KEEL DR	CORONA DEL MAR	CA	92625
9. NAME				
10. NAME				

11. NUMBER OF VACANCIES ON THE BOARD OF DIRECTORS, IF ANY:

AGENT FOR SERVICE OF PROCESS (If the agent is an individual, the agent must reside in California and Item 13 must be completed with a California street address (a P.O. Box address is not acceptable) If the agent is another corporation, the agent must have on file with the California Secretary of State a certificate pursuant to Corporations Code section 1505 and Item 13 must be left blank.)

12. NAME OF AGENT FOR SERVICE OF PROCESS
NGUYEN HUONG LUU

	CITY	STATE	ZIP CODE
13. STREET ADDRESS OF AGENT FOR SERVICE OF PROCESS IN CALIFORNIA, IF AN INDIVIDUAL KEEL DR	CORONA DEL MAR	CA	92625

TYPE OF BUSINESS

14. DESCRIBE THE TYPE OF BUSINESS OF THE CORPORATION
RETAIL DRUGS STORE

15. BY SUBMITTING THIS STATEMENT OF INFORMATION TO THE CALIFORNIA SECRETARY OF STATE, THE CORPORATION CERTIFIES THE INFORMATION CONTAINED HEREIN, INCLUDING ANY ATTACHMENTS, IS TRUE AND CORRECT.

DATE	TYPE/PRINT NAME OF PERSON COMPLETING FORM	TITLE	SIGNATURE
	NGUYEN HUONG LUU	PRESIDENT	Nguyen Huong Luu

APPROVED BY SECRETARY OF STATE

SI-200 C (REV 01/2008)

Secretary of State
Business Programs Division
Business Entities - Records, P.O. Box 944260, Sacramento, CA 94244-2600

Business Entities Records - Order Form

ORDERS CANNOT BE CHANGED OR CANCELLED ONCE SUBMITTED

1. Requestor's Information — Date: 10/25/2019

Individual's name: Huong Luu

Firm name (if any): Huong Luu, PharmD, Inc

Return address: 17400 Irvine Blvd, Suite P

City: Tustin State: CA Zip: 92780

10-digit telephone number: (714) 505 - 2872

In person drop off only, please indicate type of return method requested:

☐ Mail ☐ Pick-Up

2. Order Details

Entity name: HUONG LUU, PHARMD, INC

Secretary of State Entity/File Number (recommended): C3326833

Entity type (Check 1 box): ☑ Corporation ☐ Limited Liability Company ☐ Limited Partnership ☐ General Partnership ☐ Limited Liability Partnership ☐ Other (see instructions for options): _____

3. Copy Requests – Plain (uncertified) copies are **$1.00** for the first page, **$0.50** for each additional page. Certified copies are an additional **$5.00 per document**. See instructions for additional detail.

a. Articles/Formation/Registration document only	# of plain copies_____	# of certified copies _____
b. Articles & Amendments documents only	# of plain copies_____	# of certified copies _____
c. All Amendment documents only	# of plain copies_____	# of certified copies _____
d. Last complete Statement of Information	# of plain copies_____	# of certified copies _____
e. Last no change Statement of Information	# of plain copies_____	# of certified copies _____
f. All Statements of Information	# of plain copies_____	# of certified copies _____
g. All documents and Statements of Information	# of plain copies_____	# of certified copies _____
h. Copy of: _____	# of plain copies_____	# of certified copies _____

4. Certificate/Status Requests

a. Certificate of Status (lists entity status: i.e., good standing, active, suspended, etc.) - $5.00 each	# of certificates 1
b. Certificate of Filing of All Documents (lists all documents of record) - $5.00 per document listed	# of certificates _____
c. Certificate of No Record (certifies no record of entity found) - $5.00 each	# of certificates _____
d. Status Report (computer print-out of entity record. Cannot be certified) - $4.00 each	# of reports _____

5. FAX – For an additional fee, we will FAX the requested copies/certificates to you prior to delivery of hard-copies.

☑ Domestic FAX (in U.S.) – $5.00 fee ☐ Foreign FAX (outside U.S.) – $10.00 fee FAX # 714-505-2812

THIS SECTION FOR SECRETARY OF STATE USE ONLY

Affix Cert & Seal	$ _____
Making first page	$ _____
Making additional pages	$ _____
Certificate of	$ _____
Status Report	$ _____
FAX	$ _____
Special Handling Fee	$ _____
Other	$ _____
TOTAL AMOUNT DUE	$ _____
TOTAL AMOUNT REC'D	$ _____
REFUND AMOUNT	$ _____
BALANCE DUE	$ _____

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:

HUONG LUU, PHARMD, INC.

FILE NUMBER:	C3326833
FORMATION DATE:	10/28/2010
TYPE:	DOMESTIC CORPORATION
JURISDICTION:	CALIFORNIA
STATUS:	ACTIVE (GOOD STANDING)

I, ALEX PADILLA, Secretary of State of the State of California, hereby certify:

The records of this office indicate the entity is authorized to exercise all of its powers, rights and privileges in the State of California.

No information is available from this office regarding the financial condition, business activities or practices of the entity.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of November 05, 2019.

ALEX PADILLA
Secretary of State

CFG

BOARD OF PHARMACY

LICENSING DETAILS FOR: PHY 50604

NAME: CURA PHARMACY

LICENSE TYPE: PHARMACY (COMMUNITY)

LICENSE STATUS: CLEAR

ADDRESS

17400 IRVINE BLVD STE P
TUSTIN CA 92780
ORANGE COUNTY

ISSUANCE DATE

AUGUST 4, 2011

EXPIRATION DATE

AUGUST 1, 2020

CURRENT DATE / TIME

NOVEMBER 8, 2019
6:57:23 AM

LICENSE RELATIONSHIPS

NAME: HII, JUSTINA SHIRLEY CHENG LING

ADDRESS NOT DISCLOSED

LICENSE/REGISTRATION TYPE: REGISTERED PHARMACIST

LICENSE NUMBER: 67558 **PRIMARY STATUS:** CLEAR

4F

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: Hemophilia Preferred Care of Memphis, Inc.

Physical Address: 6423 Shelby View DR, STE 104 Memphis, TN 38134-7614

Mailing Address: 6423 Shelby View DR, STE 104

City: Memphis State: TN Zip Code: 38134-7614

Telephone: (901) 725-3440 Fax: (855) 813-6583

Toll Free Number: 1-800-757-9192 ✓ (Required per NAC 639.708)

E-mail: licensing@HPCspecialtyRX.com Website: hpcspecialtypharmacy.com

Managing Pharmacist: Kristen Smith License Number: 0000026763 TN

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: Mail Order 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.

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

Kristen Smith
Print Name of Authorized Person

11/12/19
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Alabama

Parent Company if any: HPCSP Investments, LLC

Mailing Address: 2222 Sedwick Rd.

City: Durham State: NC Zip: 27713

Telephone: (919)-246-4721 Fax: 1-855-813-0583

Contact Person: Mike Pereira

For any corporation non publicly traded, disclose the following:

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

a) N/A
Name Address

b) N/A
Name Address

c) N/A
Name Address

d) N/A
Name Address

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

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

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: N/A %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:00* pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours _____

*After Hours/ Emergency Telephone consultations are available 24 hours per day, 7 days a week By a Licensed Pharmacist with access to patient records

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
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Kristen Smith

Responsible Person of Hemophilia Preferred Care of Memphis, Inc.

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

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

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

Kristen Smith

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

Kristen Smith

Print Name of Authorized Person

11/12/19

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Tennessee)
) ss.
Shelby COUNTY)

I, Kristen Smith, 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 Pharmacist in Charge for Hemophilia Preferred Care of Memphis, Inc. (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, Kristen Smith, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Kristen Smith
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
12th day of November, 2019.

NOTARY PUBLIC

GARY COOK
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

Elimination of Certificate of Good Standing by the Alabama Department of Revenue

Starting October 1, 2015, the Alabama Department of Revenue will no longer issue a Certificate of Good Standing to a requesting party, pursuant to the enactment of Alabama Senate Bill 243. Good Standing Certificates have been used for many years to confirm that a specific entity is in "good standing" with the Alabama Department of Revenue, due to the entity's payment of the Business Privilege Tax. Lenders routinely required a Certificate of Good Standing to confirm that the entity, as the borrower, has the authority to execute the loan.

Based on the law change, the Alabama Department of Revenue will now issue a Certificate of Compliance, which certifies that the entity has paid all applicable state taxes. Prior to the enactment of Senate Bill 243, the party requesting a Certificate of Good Standing would normally receive it within 24 hours of the request. The Alabama Department of Revenue has suggested that it may take up to 10 days to receive a Certificate of Compliance. The Alabama Department of Revenue has also communicated that a Certificate of Compliance will require the execution of a power of attorney form, if a party other than an officer for the entity is requesting a Certificate of Compliance.

The projected 10 day turnaround time and the power of attorney requirement will likely cause hardship to borrowers, lenders, and other parties whose business transactions require a faster turnaround time. Discussions are ongoing with the Alabama Department of Revenue to try and address these concerns. In the interim, it is important to be aware of this upcoming change and address the state tax compliance issue at an early stage of the business transaction process, especially those conducting business transactions with lenders on a regular basis.

State of Alabama
Department of Revenue

Certificate of Compliance

Hemophilia Preferred Care of Memphis, INC. is found to be in compliance for purposes of the issuance of a Certificate of Compliance from the Alabama Department of Revenue. An examination of the Alabama Department of Revenue's records for the following accounts: Corporate Income, Excise, Pass Through Entity, Business Privilege, Business & License Tax, Withholding, International Fuel Tax Agreement, International Registration Plan, and Sales and Use Tax, reveals that the aforementioned taxpayer/entity has filed all applicable tax returns and paid the tax or taxes, interest amounts, and any penalties that were reported due for all tax returns, assessments, and/or audit liabilities that were owed, as of November 08, 2019. No representation is made as to the accuracy of the amounts reported. Like all taxpayers, this taxpayer is subject to audit and billing for additional amounts for periods within the statute of limitations.

IN WITNESS WHEREOF, I hereunto set my hand this date of November 08, 2019.

Curtis E. Stewart

Disclosure Officer

Phone: 334-242-1189
Fax: 334-242-1030

Request Date: November 08, 2019
Request Code: 19110813790231

Send to State Board of Pharmacy for Completion: A separate letter is acceptable.
Do not return with application unless it has been completed by the licensing agency.

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

LICENSE VERIFICATION

Name: Hemophilia Preferred Care of Memphis, INC.

Address: 6423 Shelby View Dr, STE 104

City: Memphis State: TN Zip: 38134-7614

I hereby authorize the Tennessee State Board of Pharmacy to furnish to the Nevada State Board of Pharmacy, the information requested below.

Signature of Applicant Kristen Smith

THIS FORM MUST BE FORWARDED TO THE HOME STATE LICENSING AGENCY FOR COMPLETION. DO **NOT** WRITE BELOW THIS LINE

License Number	License Status	Date License Issued	Date License Expires
4559	licensed	9/29/2008	10/31/2020

Has this license been encumbered in any way?	Type of Encumbrance: (if any
☐ Yes ☑ No	☐ Revoked ☐ Surrendered ☐ Limited ☐ Suspended ☐ Restricted ☐ Probation Please attach copies of any pertinent legal documents

USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS IF NECESSARY

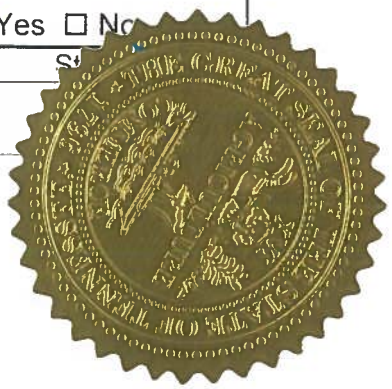
Has the applicant been convicted of any federal, state or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances? (If yes, please explain) ☐ Yes ☑ No

Has the applicant furnished any false or fraudulent material in any applications made in connection with drug manufacturing or distribution? (if yes, please explain) ☐ Yes ☑ No

Have any inspections of the applicant resulted in deficient ratings? (If yes, please explain) ☐ Yes ☑ No

Has applicant met all licensing requirements of your state? (If no, please explain) ☑ Yes ☐ No

Signature of State Official	Title	State	Date	S
Sheila W Baxter	Admin. Div.	TN	11/18/19	



11282189

47471

State of Tennessee
Department of Health

TENNESSEE BOARD OF PHARMACY
PHARMACY
HEMOPHILIA PREFERRED CARE
6423 SHELBY VIEW, SUITE 104
MEMPHIS TN 38134

This is to certify that all requirements of the State of Tennessee have been met.

ID NUMBER: 0000004559
EXPIRATION DATE: 10/31/2020

Diona E. Snyder
INTERIM DIRECTOR, HEALTH RELATED BOARDS

COMMISSIONER

DCE171

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FH1774694	10-31-2021	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	09-21-2018

HEMOPHILIA PREFERRED CARE OF MEMPHIS
HPC SPECIALTY PHARMACY
6423 SHELBY VIEW DR STE 104
MEMPHIS, TN 38134-7614

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

Hemophilia Preferred Care of Memphis, Inc. Ownership

HPCSP Investments, LLC
2222 Sedwick Road
Durham, NC 27713
FEIN: 82-3550791
Phone: 919-246-4721

Hemophilia Preferred Care of Memphis, Inc. Corporate Officers

Michael Pereira
Chief Executive Officer / President
Birch Lane
Manhasset, NY 11030
[redacted]

Cory Wiggins
Secretary
Springbank Road S
Mobile, AL 36608
[redacted]

4G

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

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: OptionOne, LLC

Physical Address: 14000 N Portland, Ste 205, Oklahoma City, OK 73134

Mailing Address: 14000 N Portland, Ste 205

City: Oklahoma City State: OK Zip Code: 73134

Telephone: 405-548-4848 Fax: 405-418-4442

Toll Free Number: 888-848-4588 ✓ (Required per NAC 639.708)

E-mail: sbryant@myoptionone.com Website: www.myoptionone.com

Managing Pharmacist: Stephanie Bryant License Number: 17502

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

Stephanie Bryant
Print Name of Authorized Person

11/7/19
Date

Board Use Only Date Processed:_____ Amount: 600.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Oklahoma

Parent Company if any: _____

Mailing Address: 14000 N Portland, Ste 205

City: Oklahoma City State: OK Zip: 73134

Telephone: 405-548-4848 Fax: 405-418-4442

Contact Person: Tracey Wills

For any corporation non publicly traded, disclose the following:

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

a) Tracey Wills (Name) Via Esperanza, Edmond, OK 73013 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. 1000 units

3) What was the price paid per share? n/a

4) What date did the corporation actually receive the cash assets? June 11, 2011

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

List any physician shareholders and percentage of ownership. attached

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:00 pm Saturday on call am _____ pm

Sunday on call am _____ pm 24 Hours _____

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

OptionOne PHARMACY

Owner/Officer:

Tracey L. Wills, CEO
Via Esperanza
Edmond, OK 73013

Officer:

Jeff M. Wills, President, CFO
Via Esperanza
Edmond, OK 73013

14000 N PORTLAND AVE, STE 205 • OKLAHOMA CITY, OK 73134-4004
O 405 • 548 • 4848 | F 405 • 418 • 4442 | MYOPTIONONE.COM

OFFICE OF THE SECRETARY OF STATE

STATE OF OKLAHOMA

CERTIFICATE OF GOOD STANDING

DOMESTIC LIMITED LIABILITY COMPANY

I, THE UNDERSIGNED, Secretary of State of the State of Oklahoma, do hereby certify that I am, by the laws of said state, the custodian of the records of the state of Oklahoma relating to the right of certain business entities to transact business in this state and am the proper officer to execute this certificate.

I FURTHER CERTIFY that OPTIONONE, LLC whose registered agent is JEFF M WILLS, with its registered office at 14000 N PORTLAND STE 205 EDMOND 73134 USA Oklahoma is a Domestic Limited Liability Company duly organized and existing under and by virtue of the laws of the state of Oklahoma and is in good standing according to the records of this office. This certificate is not to be construed as an endorsement, recommendation or notice of approval of the entity's financial condition or business activities and practices. Such information is not available from this office.

IN TESTIMONY WHEREOF, I hereunto set my hand and affixed the Great Seal of the State of Oklahoma, done at the City of Oklahoma City, this 24th, day of October, 2019.

Secretary Of State

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Stephanie Bryant

Responsible Person of OptionOne, 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

Stephanie Bryant
Print Name of Authorized Person

11/17/19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Oklahoma)
) ss.
Oklahoma COUNTY)

I, Stephanie Bryant, 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 Pharmacist in Charge for OptionOne, 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, Stephanie Bryant, 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
7th day of November, 2019.

NOTARY PUBLIC

Natalie Godwin
Notary Public in and for
STATE OF OKLAHOMA
Commission #15007267
Expires: August 6, 2023

OKLAHOMA
State Board of Pharmacy

2920 N Lincoln Blvd Ste A, Oklahoma City, OK 73105
405-521-3815 • Fax 405-521-3758

PHARMACY
#1-5739
RETAIL
EXPIRES JUL 31, 2020

OPTIONONE, LLC
14000 N PORTLAND, STE 205
OKLAHOMA CITY, OK 73134

Permits
Training Area
Drug Supplier
Sterile Compound

2020

Amount: $255.00
Receipt: 2020-0010
Date: 7/2/2019

This License is not transferable.
License must be conspicuously displayed in the location to which it is issued.

Important Information

- **Change of Location:** This license is not transferable for a change of location. A new license is required.
- **Change of Name:** This license is not transferable for a change of name. A new license is required.
- **Change of Owner:** This license is not transferable for a change of owner. A new license is required when the ownership changes by 20% or more.
- **Forms & Applications, Current Announcements and Laws & Rules are available at the Board's website:** www.pharmacy.ok.gov
- **Board Contact:**

  Email: pharmacy@pharmacy.ok.gov
  Phone: 405-521-3815
  Fax: 405-531-3758

All changes in any information required for the licensure must be reported to the Board within ten (10) days.

It is your responsibility to keep this license current.

OPTIONONE, LLC
MEMBERS' CONTRIBUTIONS AND INTERESTS

Name of Member & Address	Capital Contribution	Number of Units Issued	Percentage of Ownership	Percentage of Voting
Tracey L. Wills Via Esperanza Edmond, OK 73013		980 (1)(2)(3)	980	100
Jessica Wills Via Esperanza Edmond, OK 73013		10 (2)	10	
Matt Wills Via Esperanza Edmond, OK 73013		10 (3)	10	
Total		1,000	100%	100%

Send to State Board of Pharmacy for Completion: A separate letter is acceptable.
Do not return with application unless it has been completed by the licensing agency.

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

LICENSE VERIFICATION

Name: OptionOne, LLC

Address: 14000 N Portland, Ste, 205

City: Oklahoma City State: OK Zip: 73134

I hereby authorize the Oklahoma State Board of Pharmacy to furnish to the Nevada State Board of Pharmacy, the information requested below.

Signature of Applicant Susan Schwartz

THIS FORM MUST BE FORWARDED TO THE HOME STATE LICENSING AGENCY FOR COMPLETION. DO **NOT** WRITE BELOW THIS LINE

License Number	License Status	Date License Issued	Date License Expires
i-5739	ACTIVE	07/18/2011	07/31/2020

Has this license been encumbered in any way?	Type of Encumbrance: (if any N/A
☐ Yes ☒ No	☐ Revoked ☐ Surrendered ☐ Limited ☐ Suspended ☐ Restricted ☐ Probation Please attach copies of any pertinent legal documents

USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS IF NECESSARY

Has the applicant been convicted of any federal, state or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances? (If yes, please explain) ☐ Yes ☒ No

Has the applicant furnished any false or fraudulent material in any applications made in connection with drug manufacturing or distribution? (if yes, please explain) ☐ Yes ☒ No

Have any inspections of the applicant resulted in deficient ratings? (If yes, please explain) ☐ Yes ☒ No

Has applicant met all licensing requirements of your state? (If no, please explain) ☒ Yes ☐ No

Signature of State Official	Title	State	Date	State Seal
Jamie Thompson	Customer Service Representative	OK	10/29/2019	

OKLAHOMA STATE BOARD OF PHARMACY

4H

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: Northridge Plaza Pharmacy, Inc. d/b/a SMP Pharmacy Solutions #4

Physical Address: 18546 Roscoe Blvd. Ste 102 Northridge, CA 91324

Mailing Address: 18546 Roscoe Blvd. Ste. 102

City: Northridge State: CA Zip Code: 91324

Telephone: 818-998-8730 Fax: 818-998-8700

Toll Free Number: 844-242-3513 ✓ (Required per NAC 639.708)

E-mail: dana@smppharmacy.com Website: smppharmacy.com

Managing Pharmacist: Gilbert Andonian License Number: RPH 60412

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

Armando Bordisa
Print Name of Authorized Person

11/27/2019
Date

Board Use Only	Date Processed:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General _____ Limited ✓

Partnership Name: SMP Pharmacy Solutions #4, LLC

Mailing Address: 18546 Roscoe Blvd. Ste 102

City: Northridge State: CA Zip Code: 91324

Telephone Number: 818-998-8730 Fax Number: 818-998-8706

Contact Person: Dana Stowell (compliance manager) 855-255-5007 ext. 526

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
SMP Pharmacy Solutions #4, LLC	L	100%

List names of 4 largest partners and percentage of ownership:

Name: Armando Bardisa %: 67

Name: Philip Borden %: 16.5

Name: Zuben Shroff %: 16.5

Name: _____ %: _____

List any physician shareholders and percentage of ownership. N/A

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9:00 am 6:00 pm Saturday ~~N/A~~ _____ am _____ pm

Sunday ~~N/A~~ _____ am _____ pm 24 Hours N/A N/A

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
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Armando Bordise

Responsible Person of SMP Pharmacy Solutions

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

Armando Bordise
Print Name of Authorized Person

11/27/2016
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Florida)
) ss.
Miami - Dade COUNTY)

I, Dana Stowell, 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 Compliance Manager for SMP Pharmacy Solutions (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, [signature], do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Gerald David Henriquez
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
26th day of November, 2019.

[signature]
NOTARY PUBLIC

GERALD DAVID HENRIQUEZ
MY COMMISSION #GG346015
EXPIRES: JUN 18, 2023
Bonded through 1st State Insurance

SMP PHARMACY SOLUTIONS #4

LICENSE NUMBER: PHY 57397 **LICENSE TYPE:** PHARMACY (COMMUNITY)
LICENSE STATUS: CLEAR **EXPIRATION DATE:** FEBRUARY 15, 2020
SECONDARY STATUS: N/A
CITY: NORTHRIDGE **STATE:** CALIFORNIA **COUNTY:** LOS ANGELES **ZIP:** 91324

State of Florida
Department of State

I certify from the records of this office that SMP PHARMACY SOLUTIONS #4, LLC is a limited liability company organized under the laws of the State of Florida, filed on March 14, 2018, effective March 14, 2018.

The document number of this limited liability company is L18000066734.

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 March 19, 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 Twentieth day of May, 2019

Secretary of State

Tracking Number: 2301318090CU

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

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

2019 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT

DOCUMENT# L18000066734

FILED
Mar 19, 2019
Secretary of State
7986551186CC

Entity Name: SMP PHARMACY SOLUTIONS #4, LLC

Current Principal Place of Business:

6050 SOUTH DIXIE HIGHWAY
MIAMI, FL 33143

Current Mailing Address:

6050 SOUTH DIXIE HIGHWAY
MIAMI, FL 33143 US

FEI Number: 38-4066496

Certificate of Status Desired: No

Name and Address of Current Registered Agent:

BARDISA, ARMANDO
6050 SOUTH DIXIE HIGHWAY
MIAMI, FL 33143 US

The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

SIGNATURE:

Electronic Signature of Registered Agent — Date

Authorized Person(s) Detail :

Title	MGR
Name	BARDISA, ARMANDO
Address	6050 SOUTH DIXIE HIGHWAY
City-State-Zip:	MIAMI FL 33143

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 605, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.

SIGNATURE: BARDISA, ARMANDO MGR 03/19/2019

Electronic Signature of Signing Authorized Person(s) Detail — Date

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900 Fax: (916) 574-8618
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

August 28, 2017

Northridge Plaza Pharmacy
Attention: Rafi Ekizian
18546 Roscoe Blvd., Suite 102
Northridge, CA 91324

RE: Complaint Investigation CI 201567560

Dear Pharmacist-in-Charge:

The Board of Pharmacy has completed its investigation regarding the complaint against Northridge Plaza Pharmacy regarding sterile compounding operations without a license.

As a regulatory agency, when conducting an investigation, the Board must adhere to violations prohibited in pharmacy law. Specifically, the information and documentation obtained during the course of an investigation must clearly demonstrate that a violation of pharmacy law occurred.

The Board's analysis of the information and documentation received did not identify sufficient evidence to determine that a violation of pharmacy law occurred. Accordingly, the Board is closing the matter and will be taking no action against the pharmacy or its licensees.

Although we are closing this matter, please be advised that it is your professional responsibility to assure compliance with all pharmacy laws.

We would like to thank you for your cooperation and assistance. If you should have any questions, please contact the Board at the above address or telephone number.

Sincerely,

VIRGINIA K. HEROLD
Executive Officer

By

Tina Rojas
Complaint Unit Analyst

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FN8883729	10-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	11-04-2019

NORTHRIDGE PLAZA PHARMACY, INC.
D/B/A SMP PHARMACY SOLUTIONS #4
18546 ROSCOE BOULEVARD
SUITE 102
NORTHRIDGE, CA 91324-4667

CONTROLLED SUBSTANCE/REGULATED CHEMICAL REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223/511 (9/2016)

U.S. Department of Justice
REPORT CHANGES PROMPTLY
Drug Enforcement Administration

REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at *deadiversion.usdoj.gov* - *or*
2. call our customer Service Center at *1-(800) 882-9539* - *or*
3. submit your change(s) in writing to:
   Drug Enforcement Administration
   P.O. Box 2639
   Springfield, VA 22152-2639

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

Scanned with CamScanner

137/656 1: 7

NORTHRIDGE PLAZA PHARMACY, INC.
18546 ROSCOE BOULEVARD
SUITE 102
NORTHRIDGE, CA 91324-4667

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FN8883729	10-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	11-04-2019

NORTHRIDGE PLAZA PHARMACY, INC.
D/B/A SMP PHARMACY SOLUTIONS #4
18546 ROSCOE BOULEVARD
SUITE 102
NORTHRIDGE, CA 91324-4667

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FN8883729	10-31-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	11-04-2019

NORTHRIDGE PLAZA PHARMACY, INC.
D/B/A SMP PHARMACY SOLUTIONS #4
18546 ROSCOE BOULEVARD
SUITE 102
NORTHRIDGE, CA 91324-4667

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

Scanned with CamScanner

41

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: AdhereRx Incorporated

Physical Address: 118 MacKenan Drive, Suite 200

Mailing Address: 118 MacKenan Drive, Suite 200

City: Cary State: NC Zip Code: 27511

Telephone: 919-463-5555 Fax: 919-465-4020

Toll Free Number: 866-463-5550 ✓ (Required per NAC 639.708)

E-mail: CorporateRx@adherehealth.com Website: www.adhererx.com

Managing Pharmacist: Joshua Martin Caviness License Number: 23381 - North Carolina

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: closed door	☐	☒ 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

Jason Z. Rose
Print Name of Authorized Person

12/2/2019
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: North Carolina

Parent Company if any: PPA Holding Company

Mailing Address: 118 MacKenan Drive, Suite 200

City: Cary State: NC Zip: 27511

Telephone: 919-463-5555 Fax: 919-465-4020

Contact Person: Gail H. McKinnon

For any corporation non publicly traded, disclose the following:

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

a) PPA Holding Company (Name) 630 Fifth Avenue, Suite 400, New York, NY 10111 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. 1

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

4) What date did the corporation actually receive the cash assets? 01/05/2011

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

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: N/A %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:30 ET am 6 ET pm Saturday on call am _____ pm

Sunday on call am _____ pm 24 Hours _____

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Jason Z. Rose

Responsible Person of AdhereRx Incorporated

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

Jason Z. Rose
Print Name of Authorized Person

12/2/2019
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF North Carolina)
) ss.
Wake COUNTY)

I, Joshua Martin Caviness, 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 Pharmacist-in-Charge for AdhereRx Incorporated (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, Joshua Martin Caviness, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

SHARON J. JOHNSON NOTARY Comm Exp 3-25-2020 PUBLIC WAKE COUNTY N.C.

Joshua M Caviness
Name

SUBSCRIBED AND SWORN TO before me, a notary public this 26th day of November, 2019.

Sharon J. Johnson
NOTARY PUBLIC

Send to State Board of Pharmacy for Completion: A separate letter is acceptable.
Do not return with application unless it has been completed by the licensing agency.

Received
DEC 03 2019
NC Board of Pharmacy

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

LICENSE VERIFICATION

Name: AdhereRx Incorporated

Address: 118 MacKenan Drive, Suite 200

City: Cary State: NC Zip: 27511

I hereby authorize the North Carolina Board of Pharmacy to furnish to the Nevada State Board of Pharmacy, the information requested below.

Signature of Applicant

THIS FORM MUST BE FORWARDED TO THE HOME STATE LICENSING AGENCY FOR COMPLETION. DO **NOT** WRITE BELOW THIS LINE

License Number	License Status	Date License Issued	Date License Expires
13948	active	12/19/18	12/31/19

Has this license been encumbered in any way?	Type of Encumbrance: (if any
☐ Yes ☑ No	☐ Revoked ☐ Surrendered ☐ Limited ☐ Suspended ☐ Restricted ☐ Probation Please attach copies of any pertinent legal documents

USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS IF NECESSARY

Has the applicant been convicted of any federal, state or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances? (If yes, please explain) ☐ Yes ☑ No

Has the applicant furnished any false or fraudulent material in any applications made in connection with drug manufacturing or distribution? (if yes, please explain) ☐ Yes ☑ No

Have any inspections of the applicant resulted in deficient ratings? (If yes, please explain) ☐ Yes ☑ No

Has applicant met all licensing requirements of your state? (If no, please explain) ☑ Yes ☐ No

Signature of State Official	Title	State	Date	State Seal
Leslie Wilson	Admin	NC	12/5/19	

NORTH CAROLINA BOARD OF PHARMACY

Facility: AdhereRx Inc
Address: 118 Mackenan Dr., Suite 200 Cary, NC 27511
Permit Type: Pharmacy
Permit #: 13948
Issue Date: 12/19/2018
Expiration Date: 12/31/2019
Pharmacy Manager: Peter Anwar Saad (#20712)

NC Law requires notification of address change within 30 days.

PLEASE NOTIFY BOARD OF NAME AND/OR ADDRESS CHANGE

REFER TO YOUR LICENSE NUMBER IN ANY COMMUNICATION

Permit #: 13948

NORTH CAROLINA BOARD OF PHARMACY

2019 Pharmacy

This is to certify that

AdhereRx Inc

doing business as

AdhereRx Inc

118 Mackenan Dr., Suite 200 Cary, NC 27511 Wake

Has been renewed for the year ending December 31st 2019, as required by law and is issued to the pharmacist-manager pursuant to the representations made in application therefore. The issuance of this renewal permit is not complete and the permit is not valid until countersigned in the space indicated below by the pharmacist-manager as represented in the application. THIS PERMIT CERTIFICATE MUST BE CONSPICUOUSLY DISPLAYED IN THE PHARMACY TO WHICH IT APPLIES. Pharmacy permits are not transferable and may be revoked for the causes specified in the Law and the Rules and Regulations of the Board.

Peter Anwar Saad (#20712)

12/19/2018
Issued

PRESIDENT

EXECUTIVE DIRECTOR

NORTH CAROLINA
Department of the Secretary of State

CERTIFICATE OF EXISTENCE

I, Elaine F. Marshall, Secretary of State of the State of North Carolina, do hereby certify that

ADHERERX INCORPORATED

is a corporation duly incorporated under the laws of the State of North Carolina, having been incorporated on the 6th day of November, 2002, with its period of duration being Perpetual.

I FURTHER certify that, as of the date set forth hereunder, the said corporation's articles of incorporation are not suspended for failure to comply with the Revenue Act of the State of North Carolina; that the said corporation is not administratively dissolved for failure to comply with the provisions of the North Carolina Business Corporation Act; that its most recent annual report required by N.C.G.S. 55-16-22 has been delivered to the Secretary of State; and that the said corporation has not filed articles of dissolution as of the date of this certificate.

Scan to verify online.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at the City of Raleigh, this 21st day of November, 2019.

Elaine F. Marshall

Secretary of State

1:3
258/643

ADHERERX INC
118 MACKENAN DR
STE 200
CARY, NC 27511-3600

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BU8132639	06-30-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	02-01-2017

ADHERERX INC
118 MACKENAN DR
STE 200
CARY, NC 27511-3600

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
BU8132639	06-30-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	02-01-2017

ADHERERX INC
118 MACKENAN DR
STE 200
CARY, NC 27511-3600

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

ADHERERX INCORPORATED

F/K/A PHYSICIANS PHARMACY ALLIANCE, INC.

SHARE/UNIT JOURNAL

SHARES ISSUED

Date Issued	*Cert #*	*Registered To*	*Ledger Folio*	*No. of Shares/ Percent of Shares*	*Date Cancelled*	*Status**
01/05/11	01	PPA Holding Company		1.00000		P
		Total Outstanding Shares:		1.00000		

***P = Pledged**
C = Copy
O = Original

ADHERERX OFFICERS AND DIRECTORS RESIDENTIAL ADDRESSES

Titles	Full Name	Resident Address
Chairman (Director)	Bradley J. Mundt	1 Beacon Street Broomfield, CO 80023-8144
CEO & President (Director/Officer)	Jason Z. Rose	Governors Way Brentwood, TN 37027-8927
Vice President and Secretary (Director/Officer)	Brian S. Sauer	5th Street Manhattan Beach, CA 90266-6341

4J

818

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: Crestview Pharmacy

Physical Address: 1116 North Ferdon Blvd Crestview, FL 32536

Mailing Address: 1116 North Ferdon Blvd

City: Crestview State: FL Zip Code: 32536

Telephone: 850-683-1111 Fax: 850-683-1753

Toll Free Number: 877-821-5504 (Required per NAC 639.708)

E-mail: _____ Website: crestviewpharmacyfl.com

Managing Pharmacist: Hal Densman PharmD License Number: PS35788

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: immunization delivery

****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.

Fredrick V Da Grava

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

FREDRICK V DA GRAVA — 7-31-2019

Print Name of Authorized Person — Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DELAWARE

Parent Company if any: OPTIO RX, LLC

Mailing Address: 3225 DARLINGTON CIRCLE

City: LEXINGTON State: KY Zip: 40509

Telephone: 859-552-5013 Fax: 859-543-0234

Contact Person: VINCE DA GRAVA, PD, RPh, FASCP

For any corporation non publicly traded, disclose the following:

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

a) None
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

List any physician shareholders and percentage of ownership.

Name: NONE %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:30 am 6:00 pm Saturday 9:00 am 1:00 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: _____

Detail by Entity Name

Florida Limited Liability Company
CRESTVIEW PHARMACY, LLC

Filing Information

Document Number
L18000284682

FEI/EIN Number	59-3718091
Date Filed	12/11/2018
Effective Date	05/15/2001
State	FL
Status	ACTIVE

Last Event
CONVERSION

Event Date Filed	12/11/2018
Event Effective Date	NONE

Principal Address

1116 N FERDON BLVD
CRESTVIEW, FL 32536

Mailing Address

1116 N FERDON BLVD
CRESTVIEW, FL 32536

Registered Agent Name & Address

DENSMAN, HAL J
1116 N FERDON BLVD
CRESTVIEW, FL 32536

Authorized Person(s) Detail

Name & Address

Title AMBR

BHM CAPITAL, INC.
3084 WHITLEY OAKS LN
PACE, FL 32571

Annual Reports

No Annual Reports Filed

Document Images

No images are available for this filing.

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, FREDRICK VINCENT Da GRAVA

Responsible Person of CRESTVIEW PHARMACY

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

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

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

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

FREDRICK VINCENT Da GRAVA

Print Name of Authorized Person

8-1-2019

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF_____)
) ss.
_____COUNTY)

I, FREDRICK VINCENT DE GUANA, 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 COO for OPTIO 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,_____, 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
2 day of August, 2019.

_____
NOTARY PUBLIC

JACOB W. CALDWELL
Notary Public
Kentucky – State at Large
My Commission Expires Aug 7, 2021

4K

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: Dakota PrecisionRx, Inc.

Physical Address: 705 E. Main Ave STE 200

Mailing Address: //

City: Bismarck State: ND Zip Code: 58501

Telephone: 701-222-3360 Fax: 701-222-7506

Toll Free Number: 1-866-522-3360 (Required per NAC 639.708)

E-mail: darcy@precisionrxlabs.com Website: www.dakotarx.com

Managing Pharmacist: Joe Kaiser License Number: RPh 3934

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: Compounding	☐	☒ 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.

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

Darcy Triplett
Print Name of Authorized Person

11/11/19
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: North Dakota

Parent Company if any: _____

Mailing Address: 705 E. Main Ave Ste 200

City: Bismarck State: ND Zip: 58501

Telephone: 701-222-3360 Fax: 701-222-7506

Contact Person: Kevin Oberlander

For any corporation non publicly traded, disclose the following:

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

a) Kevin Oberlander 826 N Anderson St; Bismarck, ND 58501
Name Address

b) Donald Rush 1848 N 22nd St; Bismarck, ND 58501
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 1000

3) What was the price paid per share? $1.00

4) What date did the corporation actually receive the cash assets? 10/06/04

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

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 5 pm Saturday _____ am _____ pm

Sunday _____ am _____ pm 24 Hours _____

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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Kevin Oberlander

Responsible Person of Dakota Precision Rx, Inc.

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

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

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

Darcy Triplett

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

Darcy Triplett

Print Name of Authorized Person

11/11/19

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF North DAKOTA)
) ss.
Burleigh COUNTY)

I, Kevin Oberlander, RPh, 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 Owner for DAKOTA Precision Rx LABS (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, Kevin Oberlander, RPh, 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
13 day of November, 2019.

NOTARY PUBLIC

CHRISTOPHER D. KELLER
Notary Public
State of North Dakota
My Commission Expires Oct. 06, 2020

North Dakota Board of Pharmacy

Result Details

Company: Dakota Precision Rx Inc
Address: 705 E Main Ave
City, State, Zip: Bismarck, ND 58501
Phone: 7012223360
License Number: Phar428
Type: Pharmacy
Primary Class: Class A - Out-Patient
Date Issued: 08/23/2004
Expiration Date: 6/30/2020
Disciplinary Action: No

This data was retrieved on 12/18/2019 11:09:31 AM.

This data was last updated on 12/18/2019.

Please direct questions and comments about these results to North Dakota State Board of Pharmacy by phone, (701) 328-9535, or email.

Register: Capital Stock

From 10/06/2004 through 11/07/2019

Sorted by: Date, Type, Number/Ref

Date	Number	Payee	Account	Memo	Increase	C	Decrease	Balance
10/06/2004		KEVIN OBERLANDER	Cash in Bank-Starion [split]		400.00			400.00
10/06/2004		ANTON P WELDER	Cash in Bank-Starion [split]		600.00			1,000.00
07/01/2014	108		Capital Stock:Capital Stock-We...	To Show Interest as ...	200.00			1,200.00
07/01/2014	108		Capital Stock:Capital Stock-We...	To Show Interest as ...	600.00			1,800.00
07/01/2014	108		Capital Stock:Capital Stock-We...	To Show Interest as ...			200.00	1,600.00
07/01/2014	108		-split-	To Show Interest as ...			600.00	1,000.00

State of North Dakota
SECRETARY OF STATE

Certificate of Good Standing
of
DAKOTA PRECISIONRX, INC.

SOS Control ID#: 0000077316

Certificate #: 017447127

The undersigned, as Secretary of State of the state of North Dakota, hereby certifies that, according to the records of this office,

DAKOTA PRECISIONRX, INC.

a Corporation - Business - Domestic was formed under the laws of NORTH DAKOTA and filed with this office effective October 6, 2004. This entity has, as of the date set forth below, complied with all applicable North Dakota laws.

ACCORDINGLY, the undersigned, as such Secretary of State, and by virtue of the authority vested in him by law, hereby issues this Certificate of Good Standing.

DATE: November 7, 2019

Alvin A. Jaeger
Secretary of State

North Dakota nd.gov Official Portal for North Dakota State Government



SECRETARY OF STATE
NORTH DAKOTA

DAKOTA PRECISIONRX, INC.

Corporation Details

System ID: 20227000
Type: BUSINESS CORPORATION
Status: Active & Good Standing
Original File Date: 10/06/2004
State of Origin: North Dakota

Phone: (701) 222-3360
Effective Date: 10/06/2004

Nature of Business

STERILE COMPOUNDING OF MEDICATIONS

Principal Office

705 E MAIN AVE BISMARCK, ND 58501-4525

Registered Agent

KEVIN OBERLANDER
705 EAST MAIN AVE
PO BOX 835
BISMARCK, ND 58502-0835
Established Date: Oct 02, 2015

Authorized Shares

Class	Number	Par Value
	100000.000000	$1.000000

Generate an Annual Report To File

To Generate a Annual Report form to be filed with the Secretary of State, select the appropriate year of the report you intend to file. This report does not contain details of a report previously filed with the Secretary of State. The annual report years reflected are an indication of the various report forms available in this site and is not an indication that an entity needs to file reports for all years. Missing years indicate that the forms for the missing year have not yet been deployed to the website, or have already been removed, and can be obtained by contacting the Secretary of State.

2018 (generates a forms-fillable pdf in a new pop-up window)

Return to Search Results

Contact Us Disclaimer | Privacy Policy

We use Secure Sockets Layer (SSL) encryption technology to ensure your information is secure and protected.
Will open a new window (pop-up).
W3C WAI AA, CSS, XHTML Compliant | Copyright 2006. All Rights Reserved. The State of North Dakota.

North Dakota nd.gov Official Portal for North Dakota State Government



SECRETARY OF STATE
NORTH DAKOTA

Home | **Archived Business Records Search**

Archived Business Records Search

*** For Report Form to File, search for Entity Name and then select the year of report from the Available Report Form to File (pdf) column**

This database reflects information that is **current only as of January 11, 2019,** and includes records inactivated within the past twelve months from that date.

Search Results

New Search

Result Page: < **1** > - [Entities 1 - 1 of 1]

System ID	Entity Name	Type - Status	Available Report Form to File (pdf) (See * Below)
20227000	DAKOTA PRECISIONRX, INC.	Corporation - Active & Good Standing	2018

Result Page: < **1** > - [Entities 1 - 1 of 1]

New Search

*** Report Forms**

To generate a Report form to be filed with the Secretary of State, select the appropriate link for the report you intend to file under the Available Report Form to File column. This report does not contain details of a report previously filed with the Secretary of State. The report years reflected are an indication of the various report forms available in this site and is not an indication that an entity needs to file reports for all years. Missing years indicate that the forms for the missing years have not yet been deployed to the website, or have already been removed, and can be obtained by contacting the Secretary of State.

Please provide feedback by completing a short survey.

Contact Us Disclaimer | Privacy Policy

We use Secure Sockets Layer (SSL) encryption technology to ensure your information is secure and protected.

Will open a new window (pop-up).

W3C WAI AA, CSS, XHTML Compliant | Copyright 2006. All Rights Reserved. The State of North Dakota.

4L

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: Genesis Enterprises, Inc. DBA Genesis Pharmacy Services

Physical Address: 1876 Craigshire Rd. St. Louis, MO 63146

Mailing Address: 1876 Craigshire Rd

City: St. Louis State: MO Zip Code: 63146

Telephone: 314-485-8600 Fax: 314-485-1049

Toll Free Number: 855-485-8600 ✓ (Required per NAC 639.708)

E-mail: mfessler@genesis-rx.com Website: www.genesis-rx.com

Managing Pharmacist: Matthew Fessler License Number: 2005011040

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 <u>required</u> 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

Matthew Fessler

Print Name of Authorized Person

12-02-19

Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Missouri

Parent Company if any: n/a

Mailing Address: 1876 Craigshire Rd

City: St. Louis State: MO Zip: 63146

Telephone: 314-485-8600 Fax: 314-485-1049

Contact Person: Nicholas Rieck

For any corporation non publicly traded, disclose the following:

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

a) Nicholas Rieck (Name) N Hanley Rd, St. Louis, MO 63130 (Address)

b) Sarah Rieck (Name) White Ave, St. Louis, MO 63144 (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. 30,000

3) What was the price paid per share? $1.00

4) What date did the corporation actually receive the cash assets? 03-01-14

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

List any physician shareholders and percentage of ownership.

Name: n/a %: _____

Name: n/a %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 6 pm Saturday 7 am 11 pm

Sunday N/A am N/A pm 24 Hours N/A

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

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Missouri)
) ss.
Saint Louis COUNTY)

I, Matthew Fessler, 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 Compliance Officer for Genesis Enterprises Inc (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, Matthew Fessler, 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
2 day of DECEMBER, 2019.

Mujib A. Khan
NOTARY PUBLIC

MUJIB A. KHAN
Notary Public - Notary Seal
St Louis County - State of Missouri
Commission Number 14859070
My Commission Expires Apr 11, 2022

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Matthew Fessler

Responsible Person of Genesis Enterprises, Inc.

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

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

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

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

Matthew Fessler
Print Name of Authorized Person

12-02-19
Date

Board of Pharmacy

Pharmacy Detail

Pharmacy Primary Source Verification

The licensee search function of this website provides data extracted from our database and constitutes a Primary Source Verification.

Licensee Name:	Genesis Enterprises Inc
Profession Name:	Pharmacy
Licensee Number:	2014004392
Expiration Date:	10/31/2021
Original Issue Date:	2/13/2014
Address:	Matthew Fessler, PIC
Address Con't:	1876 Craigshire Rd
City, State Zip:	Saint Louis, MO 63146
County:	St. Louis County
Practitioner DBA Name:	Genesis Pharmacy Services
Classification:	Class A, C, D, H

Current Discipline Status:	None

Board of Pharmacy (https://pr.mo.gov/pharmacists)
3605 Missouri Boulevard
P.O. Box 625
Jefferson City, MO 65102-0625
573.751.0091 Telephone
573.526.3464 Fax
800.735.2966 TTY
800.735.2466 Voice Relay
MissouriBOP@pr.mo.gov (mailto:MissouriBOP@pr.mo.gov)
https://pr.mo.gov/pharmacists (https://pr.mo.gov/pharmacists)

STATE OF MISSOURI

John R. Ashcroft
Secretary of State

CORPORATION DIVISION
CERTIFICATE OF GOOD STANDING

I, JOHN R. ASHCROFT, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

Genesis Enterprises, Inc.
01369597

was created under the laws of this State on the 15th day of January, 2014, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 2nd day of December, 2019.

Secretary of State

Certification Number: CERT-12022019-0035

Genesis Enterprises, Inc. Officers

NICHOLAS RIECK, PRESIDENT/CFO
N HANLEY RD, ST. LOUIS, MO 63130
SSN: ; DOB); PLACE OF BIRTH: CALAMAZOO, MI
Non-Pharmacist

MATTHEW FESSLER, SECRETARY
: OTTERVILLE RD, GRAFTON, IL 62037
SSN: DOB ; PLACE OF BIRTH: WOOD RIVER, IL
Pharmacist

Updated 4-26-18

State of Missouri

Department of Insurance, Financial Institutions and Professional Registration
Division of Professional Registration
Missouri Board of Pharmacy

Pharmacy

Class A, C, D, H

VALID THROUGH OCTOBER 31, 2021
ORIGINAL CERTIFICATE/LICENSE NO. 2014004392
Matthew A Fessler - 2005011040

GENESIS ENTERPRISES INC
GENESIS PHARMACY SERVICES
MATTHEW FESSLER, PIC
1876 CRAIGSHIRE RD
SAINT LOUIS MO 63146
USA

EXECUTIVE DIRECTOR

DIVISION DIRECTOR

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FG4383321	09-30-2022	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	08-06-2019

GENESIS ENTERPRISES, INC
1876 CRAIGSHIRE RD
SAINT LOUIS, MO 63146-4006

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

1.

4M

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

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Compounding Pharmacies of Louisiana Inc. d/b/a, Professional Arts Pharmacy

Physical Address: 128 Curran Ln, Lafayette LA 70506

Mailing Address: 128 Curran Ln

City: Lafayette State: LA Zip Code: 70506

Telephone: 337-991-0101 Fax: 337-981-3774

Toll Free Number: 888-232-4737 ✓ (Required per NAC 639.708)

E-mail: davidm@professionalarts.com Website: PROFESSIONALARTS.COM

Managing Pharmacist: DAVID MAYER License Number: PST.014770

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

DAVID MAYER
Print Name of Authorized Person

11/17/2019
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Louisiana

Parent Company if any: _____

Mailing Address: 128 Curran Ln

City: Lafayette State: LA Zip: 70506

Telephone: 337-991-0101 Fax: 337-981-3774

Contact Person: David Mayer

For any corporation non publicly traded, disclose the following:

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

-> a) Eric Vidrine (Name) Princeton Woods Loop, Lafayette LA 70508 (Address)

b) David Mayer (Name) Woodbine Dr., Lafayette LA 70503 (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

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

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

List any physician shareholders and percentage of ownership.

Name: No Physician Shareholders %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:30 pm Saturday Closed am _____ 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: N/A

Professional Arts Pharmacy
Prescription Compounding Specialist

PCAB ACCREDITED™
Compounding Pharmacy

Sole Owners/Officers and Residence Addresses

1. Eric Vidrine, President

   Home: Princeton Woods Loop

   Lafayette, LA. 70508

   Ownership: 56.7%

   Louisiana Pharmacist License Number: PST.015688

   Home Phone:

2. David Mayer, Vice-President

   Home: Woodbine Dr.

   Lafayette, LA. 70503

   Ownership: 43.3%

   Louisiana Pharmacist License Number: PST.014770

   Home Phone:

128 Curran Lane • Lafayette, LA 70506 • Ph. 337-991-0101 1-888-237-4737 • Fx. 337-991-0151

Eric Vidrine, P.D. F.A.C.A., F.I.A.C.P. David Mayer, P.D Lori Maraist, P.D. Leah Albarado, Pharm.D.
Kevin LaGrange, P.D. Allison Seilhan, P.D. Shane Landry, Pharm.D. Wes Harbison, P.D.
Ashley Day, Pharm D. Kelly Marks, Pharm.D. Chelsie Head, Pharm.D. Hai Bui, Pharm.D.

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, DAVID MAYER

Responsible Person of Compounding Pharmacies of Louisiana, Inc., d/b/a, Professional Arts Pharmacy hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

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

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

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

DAVID MAYER
Print Name of Authorized Person

11/17/2015
Date



The Louisiana Board of Pharmacy certifies that it maintains the information for the credential verification function of this website, and further, performs daily updates to the website. Therefore, the website is a secure and primary source for credential verification, as authentic as a direct inquiry to the Board.

Lookup Detail View

Name and Address

Name	PublicAddress
Professional Arts Pharmacy	128 Curran Ln Lafayette, LA 70506-7222

Credential Information with supervision

License	License Type	Issue Date	Expiration Date	Status	Pharmacist In Charge
PHY.003931-IR	Pharmacy - Community ~ Independent	01/06/1998	12/31/2020	Current, without restriction or limitation	David P. Mayer

List of Current Employees

Name	License	License Type	Expiration Date	Status
Aimee V. Broussard	CPT.011878	Certified Pharmacy Technician	06/30/2020	ACTIVE
Alicia Virginia Roberts	CPT.007683	Certified Pharmacy Technician	06/30/2020	ACTIVE
Alison Guidry Newman	CPT.014221	Certified Pharmacy Technician	06/30/2020	ACTIVE
Allison T. Seilhan	PST.016670	Pharmacist	12/31/2020	ACTIVE
Ashley M. Angelle	CPT.009739	Certified Pharmacy Technician	06/30/2020	ACTIVE
Ashley W. Day	PST.019840	Pharmacist	12/31/2020	ACTIVE
Breanne Slocum McEntyre	CPT.013581	Certified Pharmacy Technician	06/30/2020	ACTIVE
Chassidy L. Guidry	CPT.008844	Certified Pharmacy Technician	06/30/2020	ACTIVE
Chelsie M. Head	PST.022505	Pharmacist	12/31/2020	ACTIVE
Cheron N. Brown	CPT.008205	Certified Pharmacy Technician	06/30/2020	ACTIVE
Courtney N. Fuhrer	CPT.010982	Certified Pharmacy Technician	06/30/2020	ACTIVE
David P. Mayer	PST.014770	Pharmacist	12/31/2020	ACTIVE
Emily N. LeGrand	CPT.010938	Certified Pharmacy Technician	06/30/2020	ACTIVE
Heidi N. Leger	CPT.008316	Certified Pharmacy Technician	06/30/2020	ACTIVE
Jenni L. Judice	CPT.005660	Certified Pharmacy Technician	06/30/2020	ACTIVE
Jepera J. Davis	CPT.007857	Certified Pharmacy Technician	06/30/2020	ACTIVE
Kasey Elizabeth Foreman	CPT.013344	Certified Pharmacy Technician	06/30/2020	ACTIVE
Kelly P. Marks	PST.019978	Pharmacist	12/31/2020	ACTIVE
Kenya R. Alexander	CPT.012630	Certified Pharmacy Technician	06/30/2020	ACTIVE
Koleen M. Major	CPT.011303	Certified Pharmacy Technician	06/30/2020	ACTIVE
Laisha J. Duhon	CPT.013316	Certified Pharmacy Technician	06/30/2020	ACTIVE
LaKayla R. Roquemore	CPT.008574	Certified Pharmacy Technician	06/30/2020	ACTIVE
Leah E. Albarado	PST.017240	Pharmacist	12/31/2020	ACTIVE
Leslie M. Turner	CPT.001208	Certified Pharmacy Technician	06/30/2020	ACTIVE
Lori M. Maraist	PST.016573	Pharmacist	12/31/2020	ACTIVE
Paige M. Ward	CPT.011044	Certified Pharmacy Technician	06/30/2020	ACTIVE

Quanjalla Henry	CPT.003794	Certified Pharmacy Technician	06/30/2020	ACTIVE
Randy J. Faulk	CPT.005836	Certified Pharmacy Technician	06/30/2020	ACTIVE
Rebecca Lynn Preston	CPT.014299	Certified Pharmacy Technician	06/30/2020	ACTIVE
Sara J. Glines	CPT.010810	Certified Pharmacy Technician	06/30/2020	ACTIVE
Scotty J. Ziesing	CPT.012861	Certified Pharmacy Technician	06/30/2020	ACTIVE
Shane M. Landry	PST.017747	Pharmacist	12/31/2020	ACTIVE
Sherri L. Howard	CPT.006384	Certified Pharmacy Technician	06/30/2020	ACTIVE
Silas Paul Capritto	CPT.014593	Certified Pharmacy Technician	06/30/2020	ACTIVE
Thanh Hai T. Bui	PST.020626	Pharmacist	12/31/2020	ACTIVE
Tina L. Dupuis	CPT.004143	Certified Pharmacy Technician	06/30/2020	ACTIVE
Wesley N. Harbison	PST.015349	Pharmacist	12/31/2020	ACTIVE

Generated on: 11/27/2019 10:53:47 AM

UNITED STATES OF AMERICA

State of Louisiana

R. Kyle Ardoin

SECRETARY OF STATE

As Secretary of State of the State of Louisiana, I do hereby Certify that

COMPOUNDING PHARMACIES OF LOUISIANA, INC.

A corporation domiciled in LAFAYETTE, LOUISIANA,

Filed charter and qualified to do business in this State on April 26, 1996,

I further certify that the records of this Office indicate the corporation has paid all fees due the Secretary of State, and so far as the Office of the Secretary of State is concerned is in good standing and is authorized to do business in this State.

I further certify that this Certificate is not intended to reflect the financial condition of this corporation since this information is not available from the records of this Office.

In testimony whereof, I have hereunto set my hand and caused the Seal of my Office to be affixed at the City of Baton Rouge on,

November 12, 2019

Secretary of State

Web 34525438D

Certificate ID: 11138474#4PK73

To validate this certificate, visit the following web site, go to **Business Services, Search for Louisiana Business Filings, Validate a Certificate**, then follow the instructions displayed.
www.sos.la.gov

LOUISIANA BOARD of PHARMACY

3388 Brentwood Drive ~ Baton Rouge, LA 70809-1700
www.pharmacy.la.gov

PHARMACY PERMIT

Permit Owner: Compounding Pharmacies of LA

This is to certify that the Pharmacy listed hereon is duly permitted to operate a PHARMACY in Louisiana for the referenced period at the address noted:

Professional Arts Pharmacy
128 Curran Ln
Lafayette, LA 70506-7222

Permit Number: PHY.003931-IR
Effective Date: 01/01/2019
Expiration Date: 12/31/2019

PHY 2019

PERMIT MUST BE DISPLAYED IN PHARMACY
THIS PERMIT IS NOT TRANSFERABLE
A change in ownership or relocation of the pharmacy requires a new permit

Carl W. Aron
President

REMINDERS

- **Relocations:** This permit is not transferable to a new address. A relocation application should be submitted at least 30 days prior to the anticipated move date.
- **Change of Ownership:** A new permit is required when the ownership of the pharmacy changes by 50% or more.
- **Controlled Dangerous Substances (CDS):** A pharmacy permit alone does not authorize the possession of Controlled Dangerous Substances. In order to procure and possess CDS, you must hold a separate CDS license.
- **Pharmacist-in-Charge (PIC):** The pharmacy shall not operate for more than ten (10) days without a designated PIC. PIC changes shall be submitted to the Board in writing.
- **Forms and applications** are available on the Board website – www.pharmacy.la.gov – under the horizontal menu "Forms & Applications."

PHYP

See Reverse Side For Easy Opening Instructions

LOUISIANA BOARD of PHARMACY
3388 Brentwood Drive
Baton Rouge, LA 70809-1700

Professional Arts Pharmacy
128 Curran Ln
Lafayette, LA 70506-7222

LOUISIANA BOARD of PHARMACY

3388 Brentwood Drive ~ Baton Rouge, LA 70809-1700
www.pharmacy.la.gov

PHARMACY PERMIT

Permit Owner: Compounding Pharmacies of LA

This is to certify that the Pharmacy listed hereon is duly permitted to operate a PHARMACY in Louisiana for the referenced period at the address noted:

Professional Arts Pharmacy
128 Curran Ln
Lafayette, LA 70506-7222

Permit Number: PHY.003931-IR
Effective Date: 01/01/2020
Expiration Date: 12/31/2020

PHY 2020

PERMIT MUST BE DISPLAYED IN PHARMACY
THIS PERMIT IS NOT TRANSFERABLE
A change in ownership or relocation of the pharmacy requires a new permit

Carl W. Aron
President

REMINDERS

- **Relocations:** This permit is not transferable to a new address. A relocation application should be submitted at least 30 days prior to the anticipated move date.
- **Change of Ownership:** A new permit is required when the ownership of the pharmacy changes by 50% or more.
- **Controlled Dangerous Substances (CDS):** A pharmacy permit alone does not authorize the possession of Controlled Dangerous Substances. In order to procure and possess CDS, you must hold a separate CDS license.
- **Pharmacist-In-Charge (PIC):** The pharmacy shall not operate for more than ten (10) days without a designated PIC. PIC changes shall be submitted to the Board in writing.
- **Forms and applications** are available on the Board website – www.pharmacy.la.gov – under the horizontal menu "Forms & Applications."

4N

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*** 03901

Check box below for type of ownership and complete all required forms.

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

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Sterling Specialty Pharmacy

Physical Address: 1312 Northland Drive

Mailing Address: Same as physical

City: Mendota Heights State: MN Zip Code: 55120

Telephone: 888-618-4126 Fax: 507-697-0082

Toll Free Number: 888-618-4126 ✓ (Required per NAC 639.708)

E-mail: tim.gallagher@sterlingspecialtyrx.com Website: www.sterlingspecialtyrx.com

Managing Pharmacist: Lyle Prussman License Number: 121233

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.

Tim Gallagher

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

Tim Gallagher - President

Print Name of Authorized Person

11/15/18

Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Minnesota

Parent Company if any: SterlingRx, Inc.

Mailing Address: 1312 Northland Drive, Suite 500

City: Mendota Heights State: MN Zip: 55120

Telephone: 888-618-4126 Fax: 507-697-0081

Contact Person: Tim Gallagher

For any corporation non publicly traded, disclose the following:

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

a) Daniel Astrup (Name) — 5 22nd St NW Austin, MN 55912 (Address)

b) Christopher Astrup (Name) — Portland Ave, Unit 502, Minneapolis, MN 55401 (Address)

c) Christopher B. Astrup Family Irrevocable GST Trust (Name) — Portland Ave, Unit 502, Minneapolis, MN 55401 (Address)

d) Daniel B. Astrup Family Irrevocable GST Trust (Name) — 22ND ST NW, Austin, MN 55912 (Address)

2) Provide the number of shares issued by the corporation. 4,000,000

3) What was the price paid per share? $0.96

4) What date did the corporation actually receive the cash assets? 12/15/2019

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

List any physician shareholders and percentage of ownership.

Name: N/A %: N/A

Name: N/A %: N/A

Hours of Operation for the pharmacy:

Monday thru Friday	7:30 am	5:30 pm	Saturday	N/A am	N/A pm
Sunday	N/A am	N/A pm	24 Hours	On-Call 888-618-4126	

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, Tim Gallagher

Responsible Person of Sterling Specialty Pharmacy

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

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

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

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

Tim Gallagher - President
Print Name of Authorized Person

11/15/19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Minnesota)
) ss.
Dakota COUNTY)

I, Tim Gallagher, 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 Sterling Specialty Pharmacy (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, Tim Gallagher, 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
19th day of November, 2019.

NOTARY PUBLIC

VILMA ALICIA CRAMER
Notary Public-Minnesota
My Commission Expires Jan 31, 2020

SterlingRx, Inc. Owners

Christopher Berg Astrup
Owner
Portland Ave, Unit 502
Minneapolis, MN 55401

DOB:
Owns 12.5%

Christopher B. Astrup Family Irrevocable GST Trust
Owns 47.5%

Daniel Berg Astrup
Owner
22nd St NW
Austin, MN 55912

DOB:
Owns 10%

Daniel B. Astrup Family Irrevocable GST Trust
Owns 30%

Officers:
President – Tim Gallagher, N Main Street, Austin, MN 55912, DOB:
Secretary – Daniel B. Astrup, 22nd St NW, Austin, MN 55912, DOB:
Treasurer- Randy Shindelar, N Main Street, Austin, MN 55912, DOB:

Office of the Minnesota Secretary of State
Certificate of Incorporation

I, Steve Simon, Secretary of State of Minnesota, do certify that: The following business entity has duly complied with the relevant provisions of Minnesota Statutes listed below, and is formed or authorized to do business in Minnesota on and after this date with all the powers, rights and privileges, and subject to the limitations, duties and restrictions, set forth in that chapter.

The business entity is now legally registered under the laws of Minnesota.

Name:	SterlingRx, Inc.
File Number:	925270700025
Minnesota Statutes, Chapter:	302A
This certificate has been issued on:	12/30/2016

Steve Simon
Secretary of State
State of Minnesota

Office of the Minnesota Secretary of State
Certificate of Good Standing

I, Steve Simon, Secretary of State of Minnesota, do certify that: The business entity listed below was filed pursuant to the Minnesota Chapter listed below with the Office of the Secretary of State on the date listed below and that this business entity is registered to do business and is in good standing at the time this certificate is issued.

Name:	SterlingRx, Inc.
Date Filed:	12/30/2016
File Number:	925270700025
Minnesota Statutes, Chapter:	302A
Home Jurisdiction:	Minnesota

This certificate has been issued on: 01/30/2018



Steve Simon
Secretary of State
State of Minnesota

State of Minnesota

BOARD OF PHARMACY
2829 UNIVERSITY AVE SE #530
MINNEAPOLIS, MN 55414-3251

HAS ISSUED

PHARMACY LICENSE NUMBER: 265419
(ACTIVE)
Community/Outpatient, Nonsterile Product Compounding, Sterile Product Compounding

To:

STERLING SPECIALTY PHARMACY
1312 NORTHLAND DRIVE, SUITE 500
MENDOTA HEIGHTS MN 55120

EFFECTIVE DATE
05/17/2019

EXPIRATION DATE
06/30/2020

State of Minnesota

BOARD OF PHARMACY
2829 UNIVERSITY AVE SE #530
MINNEAPOLIS, MN 55414-3251

HAS ISSUED

PHARMACY LICENSE
NUMBER: 265419 (ACTIVE)
Check with MN Board of Pharmacy

To:

STERLING SPECIALTY PHARMACY

EFFECTIVE DATE
05/17/2019

EXPIRATION DATE
06/30/2020

10024490.1/000047

0:1
47/85

STERLING SPECIALTY PHARMACY
1312 NORTHLAND DRIVE
SUITE 500
MENDOTA HEIGHTS, MN 55120-1140

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FS7176971	02-29-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	10-24-2017

STERLING SPECIALTY PHARMACY
1312 NORTHLAND DRIVE
SUITE 500
MENDOTA HEIGHTS, MN 55120-1140

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FS7176971	02-29-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5	RETAIL PHARMACY	10-24-2017

STERLING SPECIALTY PHARMACY
1312 NORTHLAND DRIVE
SUITE 500
MENDOTA HEIGHTS, MN 55120-1140

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

40

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: TRINITY COMPOUNDING EXPERTS LLC

Physical Address: 6631 ORION DRIVE #112 , FORT MYERS , FL ,33912

Mailing Address: 6631 ORION DRIVE #112 ,

City: FORT MYERS , State: FL , Zip Code: 33912

Telephone: 239-690-7700 Fax: 239-288-2578

Toll Free Number: 844-804-4445 ✓ (Required per NAC 639.708)

E-mail: DEANNA@APOTHICARE360.COM Website: WWW.APOTHICARE360.COM

Managing Pharmacist: JOSEPH CATALANO License Number: PS39923

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 <u>required</u> 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.

Deanna Catalano

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

DEANNA CATALANO

Print Name of Authorized Person

NOV 19 2019

Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: FL

Parent Company if any: N/A

Mailing Address: 6631 ORION DRIVE #112 ,

City: FORT MYERS , State: FL , Zip: 33912

Telephone: 239-690-7700 Fax: 239-288-2578

Contact Person: DEANNA CATALANO

For any corporation non publicly traded, disclose the following:

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

a) DEANNA CATALANO (Name) 6631 ORION DRIVE #112 , FORT MYERS , FL ,33912 (Address)

b) JOSEPH CATALANO (Name) 6631 ORION DRIVE #112 , FORT MYERS , FL ,33912 (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

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

3) What was the price paid per share? 0

4) What date did the corporation actually receive the cash assets? 2/23/18

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

List any physician shareholders and percentage of ownership.

Name: DEANNA CATALANO %: 50%

Name: JOSEPH CATALANO %: 50%

Hours of Operation for the pharmacy:

Monday thru Friday	8:30	am	5:30	pm	Saturday	CLOSE	am	pm
Sunday	CLOSE	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

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

DEANNA CATALANO

JOSEPH CATALANO

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, DEANNA CATALANO

Responsible Person of TRINITY COMPOUNDING EXPERTS 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.

Deanna Catalano

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

DEANNA CATALANO

Print Name of Authorized Person

NOV 19 2019

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Florida)
) ss.
Lee COUNTY)

I, JOSEPH CATALANO, 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 PHARMACIST IN CHARGE / PARTNER for TRINITY COMPOUNDING EXPERTS 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, JOSEPH CATALANO, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

SUBSCRIBED AND SWORN TO
before me, a notary public this
19th day of November, 2019.

NOTARY PUBLIC

JULIE CELOZZI
NOTARY PUBLIC
STATE OF FLORIDA
My Comm. Expires
February 27, 2020
No. FF 953631

November 21, 2019

Trinity Compounding Experts LLC DBA ApothiCar
Deanna Catalano
6631 Orion Dr.Suite 112
Fort Myers, FL 33912

RE: License Certification for Trinity Compounding Experts Llc

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Pharmacy
LICENSE NUMBER:	PH31213
ORIGINAL CERTIFICATION:	02/23/2018
EXPIRATION DATE:	02/28/2021
CURRENT STATUS OF LICENSE:	CLEAR,
AGENCY ACTION:	No

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595, option 5.

Sincerely,

Willie Gaines
Regulatory Specialist II

Florida Department of Health
Division of Medical Quality Assurance• Bureau of Operations
4052 Bald Cypress Way, Bin C10 • Tallahassee, FL 32399-3251
PHONE: (850) 488-0595 • FAX : (850) 245-4791

Apothicare 360

ORGANIZATION CHART

Corporation Info

TRINITY COMPOUNDING EXPERTS LLC

6631 ORION DRIVE SUITE 112, FORT MYERS, FL , 33912

Corporate Officer

DEANNA CATALANO

Title: Member

Corporate Officer

JOSEPH CATALANO

Title: Member

EIN :82-2158652

Department of Health

License Number: PH31213

Data As Of 11/13/2019

Profession	Pharmacy	
License	PH31213	
License Status	CLEAR/	
Qualifications	Schedule II & III	Community Pharmacy
License Expiration Date	2/28/2021	
License Original Issue Date	02/23/2018	
Address of Record	6631 Orion Drive #112 FORT MYERS, FL 33912	
Discipline on File	No	
Public Complaint	No	

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Certified Copy

I certify the attached is a true and correct copy of the Articles of Organization of TRINITY COMPOUNDING EXPERTS, LLC, a limited liability company organized under the laws of the state of Florida, filed electronically on July 13, 2017, as shown by the records of this office.

I further certify that this is an electronically transmitted certificate authorized by section 15.16, Florida Statutes, and authenticated by the code noted below.

The document number of this limited liability company is L17000150208.

Authentication Code: 170713094703-200301332332#1

Given under my hand and the
Great Seal of the State of Florida
at Tallahassee, the Capital, this the
Thirteenth day of July, 2017

Ken Detzner
Secretary of State

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: Trinity Compounding Experts, PLLC
Name of Limited Liability Company

The enclosed Articles of Amendment and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Cheyenne Moseley
Name of Person

Legalzoom.com, Inc.
Firm/Company

101 N. Brand Blvd., 11th Floor
Address

Glendale, CA 91203
City/State and Zip Code

frontrowjoe366@yahoo.com
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Cheyenne Moseley at (800) 773-6883 ext. 9724
Name of Person — Area Code — Daytime Telephone Number

Enclosed is a check for the following amount:

☐ $25.00 Filing Fee

☐ $30.00 Filing Fee & Certificate of Status

☒ $55.00 Filing Fee & Certified Copy (additional copy is enclosed)

☐ $60.00 Filing Fee, Certificate of Status & Certified Copy (additional copy is enclosed)

MAILING ADDRESS:
Registration Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

STREET/COURIER ADDRESS:
Registration Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, FL 32301

*change of LLC address

L19000150208

Florida Department of State
Division of Corporations
Electronic Filing Cover Sheet

Note: Please print this page and use it as a cover sheet. Type the fax audit number (shown below) on the top and bottom of all pages of the document.

(((H19000195440 3)))

H190001954403ABC0

Note: DO NOT hit the REFRESH/RELOAD button on your browser from this page. Doing so will generate another cover sheet.

To:
Division of Corporations
Fax Number : (850)617-6383

From:
Account Name : LEGALZOOM.COM INC.
Account Number : I20010000062
Phone : (323)962-8600
Fax Number : (323)962-3889

Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.

Email Address: _____

19 JUN 24 AM 10:50

LLC AMND/RESTATE/CORRECT OR M/MG RESIGN
TRINITY COMPOUNDING EXPERTS, LLC

Certificate of Status	0
Certified Copy	1
Page Count	05
Estimated Charge	$55.00

D SCOTT
JUN 25 2019

Electronic Filing Menu Corporate Filing Menu Help

ARTICLES OF AMENDMENT
TO
ARTICLES OF ORGANIZATION
OF

Trinity Compounding Experts, PLLC
(Name of the Limited Liability Company as it appears on our records)
(A Florida Limited Liability Company)

The Articles of Organization for this Limited Liability Company were filed on 07/13/2017 and assigned Florida document number L17000150208.

This amendment is submitted to amend the following:

A. If amending name, enter the new name of the limited liability company here:

The new name must be distinguishable and end with the words "Limited Liability Company," the designation "LLC" or the abbreviation "L.L.C."

Enter new principal office address, if applicable:
(Principal office address MUST BE A STREET ADDRESS)
6631 Orion Dr. Ste. 112
Ft. Myers, Florida 33912

Enter new mailing address, if applicable:
(Mailing address MAY BE A POST OFFICE BOX)
6631 Orion Dr. Ste. 112
Ft. Myers, Florida 33912

B. If amending the registered agent and/or registered office address on our records, enter the name of the new registered agent and/or the new registered office address here:

Name of New Registered Agent:

New Registered Office Address:
New Florida street address
City, Florida *Zip Code*

New Registered Agent's Signature, if changing Registered Agent:

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 obligations of my position as registered agent as provided for in Chapter 605, F.S. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.

If Changing Registered Agent, Signature of New Registered Agent

B. If amending any other information, enter change(s) here: *(Attach additional sheets, if necessary.)*

E. Effective date, if other than the date of filing: _____ (optional)
(The effective date must be specific, cannot be prior to date of receipt or filed date and cannot be more than 90 days after the date this document is filed by the Florida Department of State)

Dated June 14, 2019.

Deanna Cataldo
Signature of a member or authorized representative of a member

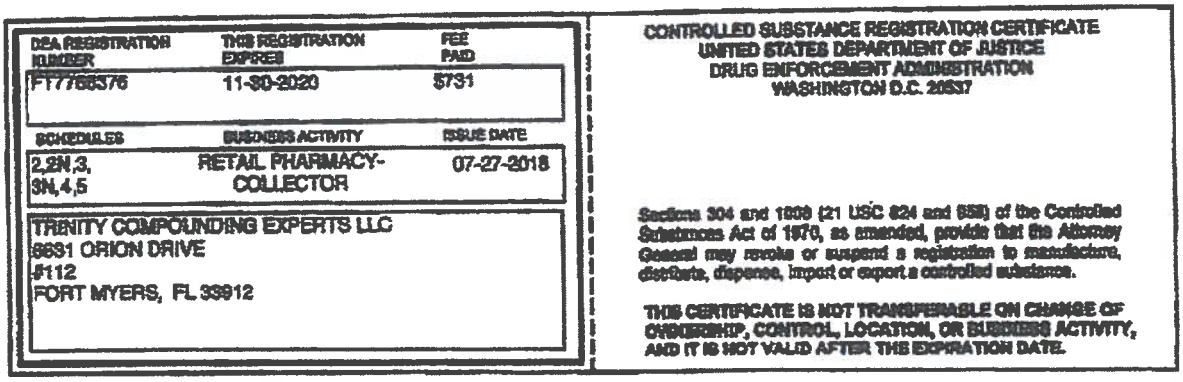
Deanna Cataldo
Typed or printed name of signee

Filing Fee: $25.00

If amending the Managers or Authorized Member on our records, enter the title, name, and address of each Manager or Authorized Member being added or removed from our records:

MGR = Manager
AMBR = Authorized Member

Title	Name	Address	Type of Action
AMBR	CATALANO, JOSEPH	MORNING SUN LN.	☐ Add
		NAPLES, FL 34119	☒ Remove
AMBR	CATALANO, DEANNA	MORNING SUN LN.	☐ Add
		NAPLES, FL 34119	☒ Remove
AMBR	CATALANO, JOSEPH	Orion Dr. Ste. 112	☒ Add
		Ft. Myers, Florida 33912	☐ Remove
AMBR	CATALANO, DEANNA	Orion Dr. Ste. 112	☒ Add
		Ft. Myers, Florida 33912	☐ Remove
			☐ Add
			☐ Remove
			☐ Add
			☐ Remove



DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FT7766376	11-30-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3, 3N,4,5	RETAIL PHARMACY-COLLECTOR	07-27-2018

TRINITY COMPOUNDING EXPERTS LLC
6631 ORION DRIVE
#112
FORT MYERS, FL 33912

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FT7766376	11-30-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N,3, 3N,4,5	RETAIL PHARMACY-COLLECTOR	07-27-2018

TRINITY COMPOUNDING EXPERTS LLC
6631 ORION DRIVE
#112
FORT MYERS, FL 33912

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

AC#3755649

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/30/2019	PH 31213	110015

QUALIFICATION(S):
COMMUNITY PHARMACY
SCHEDULE II & III

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

Expiration Date: **FEBRUARY 28, 2021**

TRINITY COMPOUNDING EXPERTS LLC
Apothicare 360
6631 ORION DRIVE
#112
FORT MYERS, FL 33912

Ron DeSantis
GOVERNOR

DISPLAY IF REQUIRED BY LAW

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

AC# 3755649

DATE	LICENSE NO.	CONTROL NO.
01/30/2019	PH 31213	110015

QUALIFICATION(S):
Community Pharmacy
Schedule II & III

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

Expiration Date: FEBRUARY 28, 2021

TRINITY COMPOUNDING EXPERTS LLC

LICENSEE SIGNATURE

AC#

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
09/07/2019	PS 39923	306981

THE PHARMACIST

NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date: **SEPTEMBER 30, 2021**
JOSEPH ANTHONY CATALANO
6631 ORION DRIVE SUITE 112
FORT MYERS, FL - 33912

Ron DeSantis
GOVERNOR

Scott A. Rivkees, MD
State Surgeon General

DISPLAY IF REQUIRED BY LAW

State of Florida
Department of State

I certify from the records of this office that TRINITY COMPOUNDING EXPERTS, LLC is a limited liability company organized under the laws of the State of Florida, filed on July 13, 2017.

The document number of this limited liability company is L17000150208.

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 9, 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 October, 2019

Secretary of State

Tracking Number: 0907001540CU

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

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

4P

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☐ Ownership Change
(Please provide current license number if making changes: MP or MW_____)

10K

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

FACILITY INFORMATION

Facility Name: AB Sciex LLC

Physical Address: 500 Old Connecticut Path, Building B
(This must be a business address, we can not issue a license to a home address)

Mailing Address: same as above

City: Framingham, MA State: Zip Code: 01701 Telephone: 508-383-7800 Fax: 508-383-7468

E-mail: Website: www.sciex.com

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: n/a to Sun: n/a to Holidays: n/a to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Inese Lowenstein

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: Mass Spectrometers, Vit D Assay Kit

**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: N/A Telephone:

APPLICATION FOR OUT-OF-STATE 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:

N/A		

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 ☒

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 ☒

Are any of the owners health professionals? If yes, please list name.

- Practitioner — Name: N/A
- Advanced Practitioner of Nursing — Name: N/A
- Physician's Assistant — Name: N/A
- Physical Therapist — Name: N/A
- Occupational Therapist — Name: N/A
- Registered Nurse — Name: N/A
- Respiratory Therapist — Name: N/A

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

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Danaher Corporation

Corporation Name: AB Sciex LLC

Mailing Address: 500 Old Connecticut Path, Building B

City: Framingham State: MA Zip: 01701

Telephone: 508-383-7700 Fax: 508-383-7468

License Contact Person: Michael Cowhig

Ownership Information – Complete Section 1 or 2

Do not use N/A in this section – Section 1 or 2 must be completed.

Section 1: List the corporations four largest shareholders:
(Name and percentage of ownership)

1. The Vanguard Group %: 6.4%
2. BlackRock, Inc. %: 6.1%
3. Steven M. Rales %: 6%
4. Mitchell P. Rales %: 5%

Section 2: If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: ABSciexLLC - Oct 6, 2009 Parent Co - Danaher Oct 3, 1986

Registration number issued: _____

Stock Exchange: Danaher NYSE

Include with the application for a publicly traded corporation

List of officers and directors.

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.

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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

Michael T. Cowhig
Print Name of Authorized Person

12/10/2019
Date

Board Use Only	Received:_____	Amount: _____

Current Appointments

AB Sciex LLC

Date 10/24/2019

Board Positions

Name	Position	Appointed	Reminder	Att.
Lutz, Robert	Manager	Unknown		
McFaden, Frank	Manager	04/12/2010		

Officers

Name	Position	Appointed	Reminder	Att.
Lowenstein, Inese	President	10/09/2017		
Blair, Rainer	Vice President	11/19/2014		
Clark, Andrew	Vice President	04/09/2013		
Cornell, Brett	Vice President	07/14/2015		
Lutz, Robert	Vice President	Unknown		
McFaden, Frank	Vice President & Treasurer	Unknown		
Tursi, Adam	Asst. Secretary/Asst. Treasurer	09/11/2018		
O'Reilly, James	Vice President & Secretary	Unknown		

Danaher - Corporate Parent

Directors

DONALD J. EHRLICH
Former President and Chief Executive Officer
Schwab Corporation

LINDA HEFNER FILLER
Former President of Retail Products and Chief Merchandising Officer
Walgreen Co.

THOMAS P. JOYCE, JR.
President and Chief Executive Officer
Danaher Corporation

TERI LIST-STOLL
Executive Vice President, Chief Financial Officer
Gap Inc.

WALTER G. LOHR, JR.
Retired Partner
Hogan Lovells

MITCHELL P. RALES
Chairman of the Executive Committee
Danaher Corporation

STEVEN M. RALES
Chairman of the Board
Danaher Corporation

JOHN T. SCHWIETERS
Principal
Perseus TDC

ALAN G. SPOON
Consultant
Polaris Partners

RAYMOND C. STEVENS, PH.D.
Provost Professor of Biological Sciences and Chemistry
Director of The Bridge Institute
The University of Southern California

ELIAS A. ZERHOUNI, M.D.
Former President
Global Research and Development
Sanofi S.A.

Executive Officers

STEVEN M. RALES
Chairman of the Board

MITCHELL P. RALES
Chairman of the Executive Committee

THOMAS P. JOYCE, JR.
President and Chief Executive Officer

RAINER M. BLAIR
Executive Vice President

DANIEL L. COMAS
Executive Vice President

WILLIAM K. DANIEL, II
Executive Vice President

MATTHEW R. McGREW
Executive Vice President and Chief Financial Officer

JOAKIM WEIDEMANIS
Executive Vice President

BRIAN W. ELLIS
Senior Vice President and General Counsel

WILLIAM H. KING
Senior Vice President
Strategic Development

ANGELA S. LALOR
Senior Vice President
Human Resources

ROBERT S. LUTZ
Senior Vice President
Chief Accounting Officer

DANIEL A. RASKAS
Senior Vice President
Corporate Development

...Previous

Supplemental Reconciliation of Non-GAAP Financial Information to Corresponding Financial Information Presented in Accordance with GAAP

Comparison of 5-Year Cumulative Total Shareholder Return

Directors & Executive Officers

Shareholder Information

TOPPAN MERRILL

powered by EZ OnlineDocuments

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DANAHER CORPORATION" IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTIETH DAY OF OCTOBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

2103594 8300

SR# 20197807291

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 203896442

Date: 10-30-19

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "AB SCIEX LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTIETH DAY OF OCTOBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.





4738932 8300

SR# 20197806960

Authentication: 203896288

Date: 10-30-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/25/2019

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 MARSH USA INC. 1050 CONNECTICUT AVENUE, SUITE 700 WASHINGTON, DC 20036-5386 Attn: Danaher.certrequest@marsh.com Fax (212) 948-0503 CN102997607-ALL-7/1-19-20 ABSCIX NO	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED AB SCIEX LLC 1201 RADIO ROAD REDWOOD CITY, CA 94065	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** ACE American Insurance Company — 22667 **INSURER B :** Indemnity Ins Co Of North America — 43575 **INSURER C :** ACE Fire Underwriters Insurance Company — 20702 **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-006500596-01 **REVISION NUMBER:** 1

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 X Contractual Liability X Broad Form PD GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:			HDO G7156860A	07/01/2019	07/01/2020	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG [ ]	$ 2,000,000 $ 2,000,000 $ 10,000 $ 2,000,000 $ 5,000,000 $ 5,000,000 $
A	**AUTOMOBILE LIABILITY** X ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY			ISA H25298512	07/01/2019	07/01/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) [ ]	$ 5,000,000 $ $ $ $
	[ ] **UMBRELLA LIAB** [ ] OCCUR [ ] **EXCESS LIAB** [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE [ ]	$ $ $
B A C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N [N] If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WLR C66037460 (AOS) WLR C66037423 (CA,MA,AZ) SCF C66037381 (WI)	07/01/2019 07/01/2019 07/01/2019	07/01/2020 07/01/2020 07/01/2020	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 2,000,000 $ 2,000,000 $ 2,000,000

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

EVIDENCE OF INSURANCE

CERTIFICATE HOLDER

AB SCIEX LLC
1201 RADIO ROAD
REDWOOD CITY, CA 94065

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
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

© 1988-2016 ACORD CORPORATION. All rights reserved.

4Q

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☑ Ownership Change

(Please provide current license number if making changes: MP or MW 01550)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☑ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Allegro Enterprises, Inc.

Physical Address: 360 Veterans Parkway, Suite 115, Bolingbrook, IL 60440

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

c/o State License Servicing

Mailing Address: 1751 State Route 17A, Suite 3

City: Florida State: NY Zip Code: 10921

Telephone: (630) 771-7402 Fax: (866) 590-5721

E-mail: AGO@slsny.com Website: www.allegromedical.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 7:00 am to 7:00 pm Tue: 7:00 am to 7:00 pm Wed: 7:00 am to 7:00 pm Thu: 7:00 am to 7:00 pm

Fri: 7:00 am to 7:00 pm Sat: Closed Sun: Closed Holidays: N/A

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Kray Allen Kibler

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: Electrotherapy, Wound Care, Personal care, Daily living aids, Incontinence Care, & Surgical Supplies.

**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: Kray Allan Kibler Telephone: (630) 771-7402

APPLICATION FOR OUT-OF-STATE 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:

N/A

_____ _____ _____

_____ _____ _____

_____ _____ _____

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 ☒

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 ☒

Are any of the owners health professionals? If yes, please 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.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 ☒

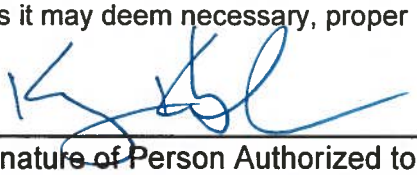
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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 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 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

Krey Allan Kibler
Print Name of Authorized Person

10/30/19
Date

Board Use Only	Received: _____	Amount: _____

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: DE

Parent Company if any: Scrip Products Corporation

Corporation Name: Allegro Enterprises, Inc.

Mailing Address: c/o State License Servicing
1751 State Route 17A, Suite 3

City: Florida State: NY Zip: 10921

Telephone: (845) 544-2482 Fax: (845) 544-2481

Contact Person: Jennifer Schneider

For any corporation non publicly traded, disclose the following:

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

a) Scrip Products Corporation (Name) 360 Veterans Parkway # 115 Bolingbrook IL, 60440 (Address) 100% Owner

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. Scrip Products Corporation - 100% Sole Owner

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

Include 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.

Allegro Enterprises, Inc.

Corporate Address: 360 Veterans Parkway, # 115, Bolingbrook, IL 60440 USA
FEIN: 86-0897987
www.allegromedical.com

Drug Labeler Code: N/A
Incorporation State: AZ
Incorporation Date: 12/1/1997

FACILITY INFORMATION

Code	Address	FDA	DEA	DUNS	VAWD	Phone	Fax
BGK	360 Veterans Parkway Suite 115 Bolingbrook, IL 60440 County: Will	N/A	N/A	N/A	No	(630) 771-7402	(866) 590-5721

FACILITY DESIGNATED REPRESENTATIVES

Name	Address	Title	Prescribing Authority	
Kray Allan Kibler	. Wiesbrock Lane Batavia, IL 60510	President & CEO	No	*Signing Officer*

OWNERSHIP

Name	Address	Title	Percent of Ownership	Prescribing Authority
Scrip Products Corporation	Veterans Parkway # 115 Bolingbrook, IL 60440		100	

LIST OF OFFICERS

Name	Address	Title	Prescribing Authority	
Peter A Roggeman	N. Elmhurst Avenue Mt. Prospect, IL 60056-2425	Vice President & Asst Secy	No	
Kray Allan Kibler	Wiesbrock Lane Batavia, IL 60510	President & CEO	No	*Signing Officer*

REGISTERED AGENT IN ALL APPLICABLE STATES

Name
National Registered Agents, Inc.
CT Corporation System

Company Particulars

Home State

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
203.001874

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES:
03/31/2021

HOME MEDICAL EQUIPMENT AND SERVICES PROVIDER

ALLEGRO ENTERPRISES INC
KRAY ALLAN KIBLER
360 VETERANS PKWY STE 115
BOLINGBROOK, IL 60440-4673

DEBORAH HAGAN
SECRETARY

CECILIA ABUNDIS
ACTING DIRECTOR

The official status of this license can be verified at www.idfpr.com

12809839

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4034407

Insurance

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/09/2018

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	Van Wyk Risk Solutions 2237 Wealthy Street SE Suite 200 Grand Rapids, MI 49506	CONTACT NAME: Richard Eitman PHONE (A/C, No, Ext): (616)942-5070 FAX (A/C, No): (616)942-8199 E-MAIL ADDRESS: ricke@vanwykcorp.com	
		INSURER(S) AFFORDING COVERAGE	NAIC #
		INSURER A : Phoenix Insurance Company	
INSURED	Scrip Holding Corporation, Scrip, Inc., Advantage Medical Equipment Supply, Inc. and Allegro Enterprises, Inc., Et al. 360 Veterans Parkway, Suite 115 Bolingbrook, IL 60440	INSURER B : Charter Oak Fire Insurance Company	
		INSURER C : Travelers Property Casualty Company of America	
		INSURER D : Medmarc Insurance Group	
		INSURER E :	
		INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** 18-19 **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:			630-0L549556	7/10/2018	7/10/2019	EACH OCCURRENCE	$	1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$	300,000
							MED EXP (Any one person)	$	10,000
							PERSONAL & ADV INJURY	$	1,000,000
							GENERAL AGGREGATE	$	2,000,000
							PRODUCTS - COMP/OP AGG	$	See Below
								$	
B	AUTOMOBILE LIABILITY ☑ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☑ HIRED AUTOS ONLY ☑ NON-OWNED AUTOS ONLY			BA-0L322952	7/10/2018	7/10/2019	COMBINED SINGLE LIMIT (Ea accident)	$	1,000,000
							BODILY INJURY (Per person)	$	
							BODILY INJURY (Per accident)	$	
							PROPERTY DAMAGE (Per accident)	$	
							Underinsured motorist	$	1,000,000
C	☑ UMBRELLA LIAB ☑ OCCUR EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☑ RETENTION $ 10,000			CUP-0L565544	07/10/2018	07/10/2019	EACH OCCURRENCE	$	10,000,000
							AGGREGATE	$	10,000,000
							Products Liability	$	Excluded
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N / N/A If yes, describe under DESCRIPTION OF OPERATIONS below			UB-0L535933	7/10/2018	7/10/2019	☑ PER STATUTE ☐ OTH-ER		
							E.L. EACH ACCIDENT	$	1,000,000
							E.L. DISEASE - EA EMPLOYEE	$	1,000,000
							E.L. DISEASE - POLICY LIMIT	$	1,000,000
D	Products Liability			N17IL380022	7/10/2018	7/10/2019	$10,000,000 Per Occurrence $10,000,000 Policy Aggregate		
B	Auto Physical Dmg, & Hired Auto PD			BA-0L549556	7/10/2018	7/10/2019	$500 Deductible Comp & Collision		

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

CERTIFICATE HOLDER

FOR INFORMATIONAL PURPOSES

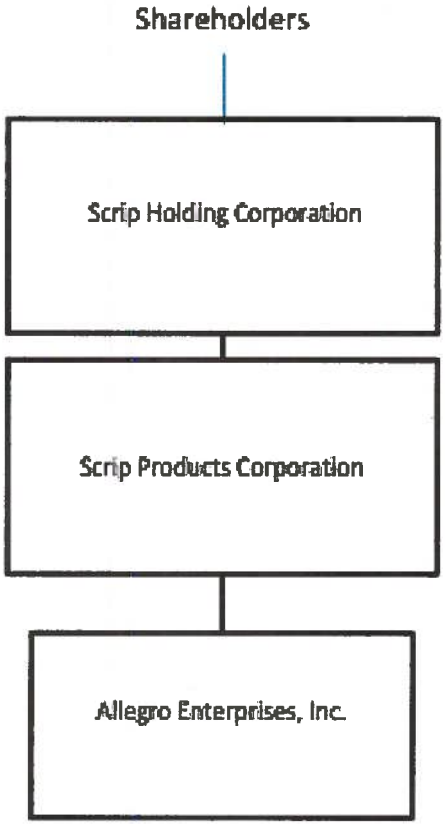
CANCELLATION

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

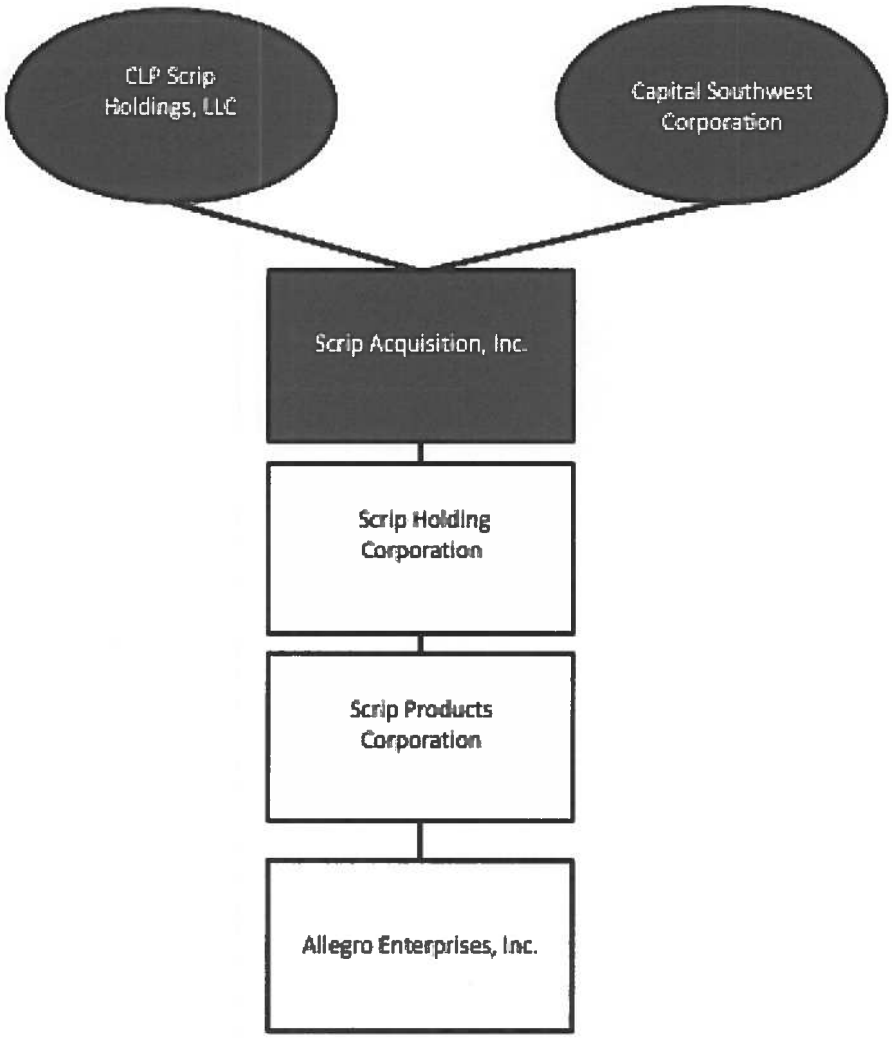
© 1988-2015 ACORD CORPORATION. All rights reserved.

Pre-Closing Corporate Structure



Org Chart

Post-Closing Corporate Structure



Articles of Incorp

STATE OF ARIZONA

Office of the
CORPORATION COMMISSION

I, Ernest G. Johnson, Executive Director of the Arizona Corporation Commission, do hereby certify that the attached copy of the following document:

ARTICLES OF INCORPORATION, 12/01/1997

consisting of 5 pages, is a true and complete copy of the original of said document on file with this office for:

ALLEGRO ENTERPRISES, INC.
ACC file number: -0825096-3

SEAL OF THE ARIZONA CORPORATION COMMISSION * 1912 * DITAT DEUS

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Arizona Corporation Commission on this date: February 4, 2011.

Executive Director

By:

ARIZONA CORPORATION COMMISSION
INCORPORATING DIVISION

Phoenix Address: 1200 West Washington
Phoenix, Arizona 85007

Tucson Address: 403 West Congress
Tucson, Arizona 85701

CERTIFICATE OF DISCLOSURE
A.R.S. Sections 10-128 & 10-1084

PLEASE SEE REVERSE SIDE

Allegro Home Health Corporation
EXACT CORPORATE NAME

CHECK APPROPRIATE BOX(ES) A or B
ANSWER "C"

THE UNDERSIGNED CERTIFY THAT

A. No persons serving either by elections or appointment as officers, directors, incorporators and persons controlling, or holding more than 10% of the issued and outstanding common shares or 10% of any other proprietary, beneficial or membership interest in the corporation

[X] 1. Have been convicted of a felony involving a transaction in securities, consumer fraud or antitrust in any state or federal jurisdiction within the seven-year period immediately preceding the execution of this Certificate.
2. Have been convicted of a felony, the essential elements of which consisted of fraud, misrepresentation, theft by false pretenses, or restraining the trade or monopoly in any state or federal jurisdiction within the seven-year period immediately preceding the execution of this Certificate.
3. Have been or are subject to an injunction, judgment, decree or permanent order of any state or federal court entered within the seven-year period immediately preceding the execution of this Certificate where such injunction, judgment, decree or permanent order
   (a) Involved the violation of fraud or registration provisions of the securities laws of that jurisdiction, or
   (b) Involved the violation of the consumer fraud laws of that jurisdiction; or
   (c) Involved the violation of the antitrust or restraint of trade laws of that jurisdiction

B. For any person or persons who have been or are subject to one or more of the statements in items A.1 through A.3 above, the following information MUST be attached:

[ ] 1. Full name and prior name(s) used
2. Full birth name.
3. Present home address
4. Prior addresses (for immediate preceding 7-year period)
5. Date and location of birth
6. Social Security number
7. The nature and description of each conviction or judicial action, date and location, the court and public agency involved and file or cause number of case.

STATEMENT OF BANKRUPTCY, RECEIVERSHIP OR REVOCATION
A.R.S. Sections 10-128.01 and 10-1083

C. Has any person serving (a) either by election or appointment as an officer, director, trustee or incorporator of the corporation or (b) major stockholder possessing or controlling any proprietary, beneficial or membership interest in the corporation, served in any such capacity or held such interest in any corporation which has been placed in bankruptcy or receivership or had its charter revoked? YES ___ NO X

IF YOUR ANSWER TO THE ABOVE QUESTION IS "YES", YOU MUST ATTACH THE FOLLOWING INFORMATION FOR EACH CORPORATION

1. Name and address of the corporation
2. Full name, including alias and address of each person involved
3. State(s) in which the corporation
   (a) Was incorporated
   (b) Has transacted business
4. Dates of corporate operation
5. A description of the bankruptcy, receivership or charter revocation, including the date, court or agency involved and the file or cause number of the case

Under penalties of law, the undersigned Incorporators/Officers declare that we have examined this Certificate, including any attachments, and to the best of our knowledge and belief it is true, correct and complete.

BY [signature] DATE 11/10/97 BY _____ DATE _____
TITLE X President/CEO/Chairman BY _____ DATE _____
BY Valerie J Park DATE 11/10/97 BY _____ DATE _____
TITLE X Director, Secretary & Treasurer TITLE _____

FISCAL DATE _____

Inc. 3002 – Foreign

AZ CORP COMMISSION
FILED

DEC 01 1997

MAR
TERM
DATE

ARTICLES OF INCORPORATION
OF
ALLEGRO HOME HEALTH CARE, INC.

1. Name. The name of the corporation (hereinafter "Corporation") shall be ALLEGRO HOME HEALTH CARE, INC.

2. Purpose. The purpose for which this Corporation is organized is the transaction of any and all lawful business for which corporations may be incorporated under the laws of the State of Arizona, as they may be amended from time to time.

3. Initial Business. The Corporation initially intends to conduct the business of providing home health care products.

4. Authorized Capital. The authorized capital stock of this Corporation shall be 1,000,000 shares, all to be shares of common stock, no par value.

5. Statutory Agent. The name and address of the initial statutory agent of the Corporation is Lawrence B. Slater & Associates, P.C., 1400 N. Gilbert Rd., #F, Gilbert, Arizona, 85234.

6. Known Place of Business. The known place of business of the Corporation shall be 2921 N. 68th St., #6, Scottsdale, Arizona, 85251, and places for conducting business, both within and without the State of Arizona, may be established from time to time by the Board of Directors.

7. Board of Directors. The initial Board of Directors shall consist of 2 directors. The persons who are elected and qualified are to serve as directors until the first annual meeting of the shareholders or until their successors are elected and qualified are:

Craig Hood
2921 N. 68th St., #6
Scottsdale, AZ 85251

Valerie Paxton
2921 N. 68th St., #6
Scottsdale, AZ 85251

Otherwise, the number of persons to serve on the Board of Directors shall be fixed by the Bylaws of the Corporation.

8. Quorum. A quorum at a meeting of the Board of Directors shall consist of one-half of the number of directors then serving or such other number as may be fixed by the Corporation's Bylaws as the same may be amended from time to time; provided that when a Board comprised of one member is authorized, then one director shall constitute a quorum.

9. Incorporators. The names and addresses of the incorporators of the Corporation are:

Craig Hood
2921 N. 68th St., #6
Scottsdale, AZ 85251

Valerie Faxon
2921 N. 68th St., #6
Scottsdale, AZ 85251

All powers, duties and responsibilities of the incorporators shall cease at the time of delivery of these Articles of Incorporation to the Arizona Corporation Commission for filing.

10. Distributions from Capital Surplus. The Board of Directors of the Corporation may, from time to time, distribute on a pro rata basis to its shareholders out of the capital surplus of the Corporation a portion of its assets, in cash or in property.

11. Indemnification of Officers, Directors, Employees and Agents. The Corporation shall indemnify, to the maximum extent, from time to time permitted by applicable law, any person who incurs liability or expense by reason of such person acting as an officer, director or agent of the Corporation. This indemnification shall be mandatory and all circumstances in which indemnification is permitted by law.

12. Repurchase of Shares. The Board of Directors of the Corporation may, from time to time, cause the Corporation to purchase its own shares to the extent of the unreserved and unrestricted earned and capital surplus of the Corporation.

13. Dividends. The Board of Directors may authorize the payment of dividends to the holders of shares of any class of stock payable in shares of any other class.

14. Liability for Breach of Fiduciary Duty. The personal liability of any director of the Corporation to the Corporation or its shareholders for monetary damages for breach of fiduciary duties as a director, is hereby eliminated to the fullest extent allowed by law and in particular A.R.S. Section 10-054 (9), as currently enacted or as the same may be amended from time to time; provided, however that except as otherwise allowed by law, in no event shall the personal liability of a director be eliminated for the following acts: (a) Any breach of the directors' duty of loyalty to the Corporation or its shareholders, (b) Acts or omissions which are not in good faith or which involve intentional misconduct or a knowing violation of law; (c) Authorizing the unlawful payment of a dividend or other distribution on the Corporation's capital stock or the unlawful purchase of its capital stock; (d) any transaction from

which the director may derive an improper personal benefit as mandated by A.R.S. Section 10-041 as amended from time to time.

IN WITNESS WHEREOF, we, the undersigned, have hereunto set our hands this 12th day of December, 1997.

CRAIG HOOD

VALERIE PAXTON

STATE OF ARIZONA)
) ss.
County of)

The foregoing was acknowledged before me this 12th day of December, 1997, by CRAIG HOOD.

"OFFICIAL SEAL"
Debra A. Casey
Notary Public-Arizona
Maricopa County
My Comm. Expires 5/31/2000

Notary Public

My commission expires:
5.31.2000

STATE OF ARIZONA)
) ss.
County of)

The foregoing was acknowledged before me this 12 day of December, 1997, by VALERIE PAXTON.

"OFFICIAL SEAL"
Debra A. Casey
Notary Public-Arizona
Maricopa County
My Comm. Expires 5/31/2000

Notary Public

My commission expires:
5.31.2000

ACCEPTANCE OF STATUTORY AGENT FOR ALLEGRO HOME HEALTH CARE, INC

I, Lawrence B Slater, of the law offices of Lawrence B. Slater & Associates P.C., having been designated to act as statutory agent, hereby consent to act in that capacity until removal or resignation is submitted in accordance with the Arizona Revised Statutes.

DATED this [redacted] day of [redacted], 1997.

SLATER & ASSOCIATES, P.C.

Lawrence B Slater

STATE OF ARIZONA

Office of the
CORPORATION COMMISSION

I, Ernest G. Johnson, Executive Director of the Arizona Corporation Commission, do hereby certify that the attached copy of the following document:

ARTICLES OF AMENDMENT, 03/03/2000

consisting of 1 pages, is a true and complete copy of the original of said document on file with this office for:

ALLEGRO ENTERPRISES, INC.
ACC file number: -0825096-3

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Arizona Corporation Commission on this date: February 4, 2011.

SEAL OF THE ARIZONA CORPORATION COMMISSION * 1912 * DITAT DEUS

Executive Director

By:

AZ. CORP. COMMISSION
DELIVERED

MAR 0 3 2000

FILED BY Mary Baines
TERM
DATE 3/3/00
0825096-3

CERTIFICATE OF AMENDMENT

OF

ARTICLES OF INCORPORATION OF

ALLEGRO-HOME HEALTH CARE, INC.

Craig Hood and Valerie Paxton certify that:

1. They are the President and Secretary, respectively, of Allegro-Home Health Care, Inc., an Arizona corporation.

2. Article 1 of the Articles of Incorporation of this corporation is amended to read as follows:

1. Name. The name of this corporation (hereinafter "Corporation") shall be Allegro Enterprises, Inc. OKM

3. Article 4 of the Articles of Incorporation of this corporation is amended to read as follows:

4. Authorized Capital. The authorized capital stock of this Corporation shall be 10,000,000 shares, all to be common stock, no par value.

4. The foregoing amendment of Articles of Incorporation has been duly approved by the Board of Directors.

5. The foregoing amendment of Articles of Incorporation has been duly approved by the required vote of shareholders in accordance with Section 10-1003 of the Arizona Business Corporation Act. The number of total outstanding shares of the corporation is 1,000 shares of common stock. The affirmative vote of more than 50% of the outstanding shares was required for approval of the amendment to the Articles of Incorporation. All of the outstanding shares voted in favor of the amendment.

We further declare under penalty of perjury under the laws of the State of Arizona that the matters set forth in this certificate are true and correct as of our own knowledge.

Executed this 1st day of December, 1999.

Craig Hood, President

Valerie Paxton, Secretary

STATE OF ARIZONA

Office of the
CORPORATION COMMISSION

I, Ernest G. Johnson, Executive Director of the Arizona Corporation Commission, do hereby certify that the attached copy of the following document:

ARTICLES OF AMENDMENT, 05/04/2005

consisting of 1 pages, is a true and complete copy of the original of said document on file with this office for:

ALLEGRO ENTERPRISES, INC.
ACC file number: -0825096-3

SEAL OF THE ARIZONA CORPORATION COMMISSION
DITAT DEUS
1912

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Arizona Corporation Commission on this date: February 4, 2011.

Executive Director

By:

AZ CORPORATION COMMISSION
FILED

MAY 04 2005

FILE NO. 0825096-3

CERTIFICATE OF AMENDMENT

OF

ARTICLES OF INCORPORATION OF

ALLEGRO ENTERPRISES, INC.

Craig Hood and Valerie Paxton certify that:

1. They are the President and Secretary, respectively, of Allegro Enterprises, Inc., an Arizona corporation.

3. Article 4 of the Articles of Incorporation of this corporation is amended to read as follows:

> 4. Authorized Capital. The authorized capital stock of this Corporation shall be 10,000,000 shares, all to be common stock, par value of $0.001 per share.

4. The foregoing amendment of Articles of Incorporation has been duly approved by the Board of Directors.

5. The foregoing amendment of Articles of Incorporation has been duly approved by the required vote of shareholders in accordance with Section 10-1003 of the Arizona Business Corporation Act. The number of total outstanding shares of the corporation is 4,025,000 shares of common stock. The affirmative vote of more than 50% of the outstanding shares was required for approval of the amendment to the Articles of Incorporation. All of the outstanding shares voted in favor of the amendment.

We further declare under penalty of perjury under the laws of the State of Arizona that the matters set forth in this certificate are true and correct as of our own knowledge.

Executed this 3rd day of May, 2005.

Craig Hood, President

Valerie Paxton, Secretary

File Number 7204-912-8

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALLEGRO ENTERPRISES, INC., INCORPORATED IN ARIZONA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MAY 23, 2019, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 7TH *day of* NOVEMBER *A.D.* 2019 .

Authentication #: 1931101916 verifiable until 11/07/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

4R

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**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

(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 1,2,3,5 ■ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: BrightChoice Medical INC

Physical Address: 7373 Hodgson Memorial Drive, Suite 3A, Savannah GA 31406

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

Mailing Address: 7373 Hodgson Memorial Drive, Suite 3A

City: Savannah State: GA Zip Code: 31406

Telephone: 888-878-6992 Fax: 888-878-9542

E-mail: DMeyer@cirrussoft.us Website: brightchoicemedical.com

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 5pm Fri: 9am to 5pm Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Thomas Schupp

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: _____

**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 OUT-OF-STATE 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:

Medicare 103341973	GA Medicaid 003121760A	

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 ◉

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 ◉

Are any of the owners health professionals? If yes, please 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.

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ◉

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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

Drew Meyer
Print Name of Authorized Person

12-6-2019
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

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

Owner's Name: Drew Meyer

List all previous names: →

Social Security Number: [redacted]

Date of Birth: [redacted]

Place of Birth: City: Fort Lauderdale State: FL Country: USA

Citizenship: USA ✓ other ____

If applicable, list Naturalization Number: ____ Passport Number: ____

Current residence address: [redacted] Greenview Terr. City: Boca Raton

State: FL Zip Code: 33433 Telephone Number: [redacted] Fax Number: -

Previous address (last 5 years):

Address: ____ City: ____ State: Zip Code: ____

Address: [redacted] Greenview Terr City: Boca Raton State: FL Zip Code: 33433

Address: 1401 SW 25th St City: Boca Raton State: FL Zip Code: 33433

Address: ____ City: ____ State: Zip Code: ____

Business Name: Bright Choice Medical, Inc.

Current Business Address: 7373 Hodgson Memorial Dr. Suite 3A

City: Savannah State: GA Zip Code: 31406

Telephone Number: [redacted] Fax Number: 888-878-9542

888-878-6992

Previous Employment (last 5 years):

Name: Cirrus Solution Address: 6600 NW 16th St Ste. Se. #1

City: Plantation State: FL Zip Code: 33313

Name: Liberty Health & life Address: 6600 NW 16th St Ste. #6

City: Plantation State: FL Zip Code: 33313

Name: ____ Address: ____

City: ____ State: ____ Zip Code: ____

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/19/2019

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
Orrino Capital Services, LLC
500 W Main Street Suite 208
Babylon NY 11702

CONTACT NAME: Certificates Department
PHONE (A/C, No, Ext): 631-669-0215 **FAX (A/C, No):** 631-669-0216
E-MAIL ADDRESS: certificates@orrinocapital.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Illinois Union Insurance Compa	27960
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED BRIGMED-01
Bright Choice Medical, Inc.
7373 Hodgson Memorial Drive
Suite 3A
Savannah GA 31406

COVERAGES **CERTIFICATE NUMBER:** 445546899 **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			MLP G28184657 003	11/8/2019	11/8/2020	EACH OCCURRENCE	$ 1,000,000
	[X] CLAIMS-MADE [ ] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
	[X] Professional Lia						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	[X] POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 1,000,000
	[ ] 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	
	ANYPROPRIETOR/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	$

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

CERTIFICATE HOLDER

National Supplier Clearinghouse
Palmetto GBA, AG-495
PO Box 100142
Columbia, SC 29202-3142

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

© 1988-2015 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

4S

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☐ Ownership 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 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Drawbridge Health, Inc

Physical Address: 11535 Sorrento Valley Road, Suite 407, San Diego, CA 92121
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 11535 Sorrento Valley Road, Suite 407

City: San Diego State: Zip Code: CA 92121 Telephone: 408-421-1510

Fax: N/A

E-mail: awright@dbhealth.com Website: https://www.dbhealth.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8am to 5pm Tue: 8am to 5pm Wed: 8am to 5pm Thu: 8am to 5pm Fri: 8am to 5pm Sat: N/A to Sun: N/A to Holidays: N/A to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Elisa Romeo

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: Medical 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: N/A Telephone: N/A

APPLICATION FOR OUT-OF-STATE 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:

N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

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 ☒

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 ☒

Are any of the owners health professionals? If yes, please list name.

- Practitioner Name: N/A
- Advanced Practitioner of Nursing Name: N/A
- Physician's Assistant Name: N/A
- Physical Therapist Name: N/A
- Occupational Therapist Name: N/A
- Registered Nurse Name: N/A
- Respiratory Therapist Name: N/A

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

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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.

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

Annie Wright
Print Name of Authorized Person

20-Nov.-2019
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: N/A

Corporation Name: Drawbridge Health, Inc

Mailing Address: 11535 Sorrento Valley Road, Suite 407

City: San Diego State: CA Zip: 92121

Telephone: 408-421-1510 Fax: N/A

Contact Person: Annie Wright, Assoc. Director, RA & QA

For any corporation non-publicly traded, disclose the following:

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

a) Lee McCracken 11535 Sorrento Valley Road, Suite 407, San Diego, CA 92121
Name Address

b) Alicia Jackson 548 Gabilan St., Los Altos, CA 94022
Name Address

c) Greg Nagy 11535 Sorrento Valley Road, Suite 407, San Diego, CA 92121
Name Address

d) Elisa Romeo 11535 Sorrento Valley Road, Suite 407, San Diego, CA 92121
Name Address

2) Provide the number of shares issued by the corporation. 30,033,182

3) What was the price paid per share? $1.75

4) What date did the corporation actually receive the cash assets? 26 July 2019 (latest)

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

Include 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.

Drawbridge HEALTH

31 October 2019

Drawbridge Health, Inc Corporate Officers

Lee R. McCracken
Chief Executive Officer
11535 Sorrento Valley Rd., Suite 407
San Diego, CA 92121

Elisa Romeo
Chief Operating Officer
11535 Sorrento Valley Rd., Suite 407
San Diego, CA 92121

Greg Nagy
Chief Marketing Officer
11535 Sorrento Valley Rd., Suite 407
San Diego, CA 92121

Holly Logue
Head of Strategic Assets
11535 Sorrento Valley Rd., Suite 407
San Diego, CA 92121

Carin Sandvik
Head of Finance & Administration
11535 Sorrento Valley Rd., Suite 407
San Diego, CA 92121

Report Date:10/31/2019	Drawbridge Health, Inc. - Detail Capitalization Table	
Name	Fully Diluted Shares	% of Fully Diluted Shares
Athena Ventures I LLC	9,859,499.00	32.83
Barkley, Maria	3,000.00	0.01
Beyerlein, Dagmar	31,250.00	0.10
Brege, Laura	50,000.00	0.17
Chapman, Rowan	60,416.00	0.20
Dokukin, Victor	22,500.00	0.07
Eichler, Gabriel	8,185.00	0.03
Gadelrab, Ruby	6,500.00	0.02
Glorikian, Harry	150,000.00	0.50
Grote, Ruby	10,500.00	0.03
Haines, Arnaud	7,000.00	0.02
Hancock, Andrew	25,000.00	0.08
Harrington, Mindy	25,417.00	0.08
Holscher, Todd	90,250.00	0.30
Imperial College Health Partners	28,500.00	0.09
Innovation Kyoto 2016 Investment Limited Partnership (Kyoto-iCap)	2,285,713.00	7.61
Jackson, Alicia	500,000.00	1.66
Jacobs-Nesselrodt, Alice	12,500.00	0.04
Jordan, Brett	76,750.00	0.26
Juneau, Kara	15,833.00	0.05
Logue, Holly	240,000.00	0.80
McCracken, Lee R.	1,501,006.00	5.00
Medi-Physics, Inc.	6,716,543.00	22.36
Mitsubishi UFJ Life Science II, Limited Partnership	285,714.00	0.95
Nagy, Greg	541,000.00	1.80
Nerlaker, Mukul	8,750.00	0.03
Olsen, Jonathan	3,315.00	0.01
Rajagopalan, Malini	5,000.00	0.02
Rava, Richard	62,499.00	0.21
Reinstein, James	216,667.00	0.72
Romeo, Elisa	541,000.00	1.80
Saed, Sabina	10,000.00	0.03
Sandvik, Carin	180,000.00	0.60
Sayeed, Imran	7,500.00	0.02
Shariff, Kamraan	360,000.00	1.20
Shores, Clyde	175,000.00	0.58
Slatore, Harold	20,000.00	0.07
Stack, Risa	100,000.00	0.33
Sumitomo Dainippon Pharma Co., Ltd.	1,142,857.00	3.81
Thorne Research, Inc.	3,142,856.00	10.46
Williamson, Lucy	604.00	0.00
Wright, Anneilynn	58,750.00	0.20
OPTIONS AVAILABLE FOR ISSUANCE	1,445,308.00	4.81
TOTALS:	**30,033,182.00**	**100.00**

Drawbridge Health, Inc.

Board of Directors

31-Oct-2019

			Individual Ownership*		Corporate Ownership	
Name	**Type**	**Representing**	**Shares**	**%**	**Shares**	**%**
Risa Stack	Chairman	Independent	100,000	0.33%	-	N/A
Alex De Winter	Member	Athena Ventures LLC (f/k/a GE Ventures)	-	N/A	9,859,499	32.83%
Paul Jacobsen	Member	Thorne, Inc.	-	N/A	3,142,856	10.46%
Lee R. McCracken	Member	Drawbridge Health, Inc.	1,501,006	5.00%	-	N/A
OPEN SEAT	Member	MediPhysics, Inc. (GEHC)	-	N/A	6,716,543	22.36%
			* Includes stock options			

Ownership*

(Top 5 persons or entities to whom shares were issued - See stock register for complete information)

Last Name	First Name	Address	SSN or Federal Tax ID	DOB (if applicable)	# of shares	Price per share	% Ownership
Athena Ventures I LLC	N/A	901 Main Avenue Norwalk, CT 06851	83-2967957	N/A	9,859,499	Various - Most recent $1.75	32.8%
Medi-Physics, Inc.	N/A	4636 Somerton Road, Bldg #1 Feasterville-Trevose, PA 19053	94-1718319	N/A	6,716,543	Various - Most recent $1.75	22.4%
Thorne Research, Inc.	N/A	620 Omni Industrial Blvd Summerville, SC 29486	91-1248086	N/A	3,142,856	$1.75	10.5%
Innovation Kyoto 2016 Investment Limited Partnership	N/A	36-1 Yoshido Honmachi Sakyo-ku, Kyoto 606-8317 Japan	N/A - Japanese entity	N/A	2,285,713	$1.75	7.6%
Sumitomo Dainippon Pharma	N/A	6-8 Doshomachi 2-chrome Chuo-Ku, Osaka 541-0045 Japan	N/A - Japanese entity	N/A	1,142,857	$1.75	3.8%

*See stock register for complete ownership information.

Corporate Structure

Name of Corp Officer

Last Name	First Name	Position	DOB	Address	% Stock Ownership
McCracken	Lee	CEO	1/6/1958	13864 Boquita Dr.	5.00%
Romeo	Elisa	COO	12/31/1978	200 Lapis Way, San Marcos, CA 92078	1.80%
Nagy	Greg	Chief Marketing Officer	3/28/1975	106 Palmer Street, San Ramon CA 94583	1.80%
Logue	Holly	Head of Strategic Assets	3/24/1975	808 Detroit Street, San Francisco 94131	0.80%
Sandvik	Carin	Head of Finance & Administration	4/8/1963	2379 Lapis Rd. Carlsbad, CA 92009	0.60%

Board of Directors

Name of Director

				Individual Ownership*		Corporate Ownership	
Last Name	First Name	Type	Representing	Shares	%	Shares	%
Stack	Risa	Chairman	Independent	100,000	0.33%	-	N/A
De Winter	Alex	Member	Athena Ventures LLC (f/k/a GE Ventures)	-	N/A	9,859,499	32.83%
Jacobsen	Paul	Member	Thorne, Inc.	-	N/A	3,142,856	10.46%
McCracken	Lee R.	Member	Drawbridge Health, Inc.	1,501,006	5.00%	-	N/A
OPEN SEAT		Member	MediPhysics, Inc. (GEHC)	-	N/A	6,716,543	22.36%

* Includes stock options

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DRAWBRIDGE HEALTH, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTIETH DAY OF OCTOBER, A.D. 2019.

Jeffrey W. Bullock, Secretary of State

5809419 8300

SR# 20196628101

Authentication: 203899798

Date: 10-30-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/5/2019

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	CONTACT NAME: Stephanie Sullivan
Electric Insurance Company 75 Sam Fonzo Drive Beverly, MA 01915-1000	PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Electric Insurance Company*	21261
INSURER B: A.M. Best FSR of A (Excellent), ICR of a+	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Drawbridge Health, Inc. 800 Long Ridge Road Fairfield, CT 06927 United States

COVERAGES **CERTIFICATE NUMBER:** 222725 **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:	X	X	GL 19-1	1/1/2019	1/1/2020	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $2,500,000 $ $50,000 $ $10,000 $ $2,500,000 $ $5,000,000 $ Included in Gen Agg
A	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	X	X	ML 19-2	1/1/2019	1/1/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $2,500,000 $ $ $
A	UMBRELLA LIAB [X] OCCUR X EXCESS LIAB [ ] CLAIMS-MADE DED [ ] RETENTION $	X	X	XS 19-1	1/1/2019	1/1/2020	EACH OCCURRENCE AGGREGATE	$ $2,500,000 $ $5,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	X	WC 19-1	1/1/2019	1/1/2020	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $2,500,000 $ $2,500,000 $ $5,000,000

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

Solely to the extent required by the underlying contract with the Named Insured, this insurance shall provide coverage on a primary and noncontributory basis and shall contain a waiver of subrogation if made in writing prior to an "occurrence" giving rise to a loss. The policies referenced above have been endorsed to provide the following notice of cancellation to the certificate holder: Should any of the above described policies be cancelled before the expiration date thereof, the issuing insurer will endeavor to mail 30 days written notice to the certificate holder, but failure to do so shall impose no obligation or liability of any kind upon the insurer affording coverage, its agents or representatives.

Please see page 2 for additional insureds and any additional language.

CERTIFICATE HOLDER

San Diego Inspire 2, LLC, a Delaware limited liability company
c/o Parallel Capital Partners
4105 Sorrento Valley Blvd
San Diego, CA 92121
United States

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

© 1988-2016 ACORD CORPORATION. All rights reserved.

AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

Page ____ of ____

AGENCY Electric Insurance Company	NAMED INSURED Drawbridge Health, Inc. 800 Long Ridge Road Fairfield, CT 06927 United States
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE: 1/1/2019

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 **FORM TITLE:** Certificate of Liability Insurance

Subject to the insurance policy terms and conditions, the above referenced General Liability, Excess Liability, and Automobile Liability policies shall include the Certificate Holder and Parallel Capital Partners, Inc., Longfellow Real Estate Partners, LLC and all affiliates (of the above) and their respective directors, officers, employees, partners and members as an additional insureds, but only to the extent required by the underlying written contract with the Named Insured that is in place prior to an "occurrence" giving rise to a loss.

Jobsite: 11535 Sorrento Valley Rd., Suite 407; 11555 Sorrento Valley Rd., Suite 102; AGP SORRENTO BUSINESS COMPLEX, L.P., Parallel Capital Partners, Inc. and
all affiliates (of the above) and their respective directors, officers, employees, partners and members are included as Additional Insureds

GL Coverages:
- a. Premises-Operations
- b. Products/Completed Operations
- c. XCU
- d. Blanket Contractual Liability
- e. Personal and Advertising Injury Limit
- f. Independent Contractors
- g. Separation of Insureds / Cross Liability
- h. Sudden and Accidental Pollution Liability

Auto Coverages:
- a. Symbol 1 - All Vehicles

Excess Liability:
- a. Following Form

WC Coverages:
- a. USL&H
- b. Jones Act / Maritime Liability
- c. Outer Continental Shelf Lands Act
- d. The Workers Compensation policy provides coverage in all states where the insured has operations, except for monopolistic states (ND, WY, PR) and states where the insured qualifies for self-insured status (OH, WA)
- e. Employers Liability coverage is provided in all states where the insured has operations

© 2008 ACORD CORPORATION. All rights reserved.
The ACORD name and logo are registered marks of ACORD

STATE OF CALIFORNIA

DEPARTMENT OF PUBLIC HEALTH
FOOD AND DRUG BRANCH

DEVICE MANUFACTURING LICENSE

Drawbridge Health, Inc
11535 Sorrento Valley Road, Suite 407
San Diego, Ca 92121

LICENSE NUMBER: 105443
EXPIRATION DATE: 7/16/2020

The person named herein is licensed to manufacture devices through the expiration date of this license. This license is issued in accordance with the provisions of Division 104, Chapter 6, Article 6 of the California Health and Safety Code and is not transferable to any other person or place. The licensee is required by law to immediately notify the California Department of Public Health of any change in the information reported in the application.

Food and Drug Branch, 1500 Capitol Avenue, MS 7602, PO Box 997435, Sacramento, CA 95899-7435 (916) 650-6500

Printed: 7/19/2019

4T

1-14

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☐ Ownership 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 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Home Sleep Delivered, L.L.C.

Physical Address: 625 E. Kaliste Saloom Road, Suite 200 S, Lafayette, LA 70508
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 625 E. Kaliste Saloom Road, Suite 200 S

City: Lafayete, LA State: Zip Code: 70508 Telephone: (337) 857-3646

Fax: (337) 857-3514

E-mail: info@homesleepdelivered.com Website: (337) 857-3646

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8am to 5pm Tue: 8am to 5pm Wed: 8am to 5pm Thu: 8am to Fri: 8am to 5pm Sat: N/A to N/A Sun: N/A to N/A Holidays: N/A to N/A

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Andrew Hill

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: _____

**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 OUT-OF-STATE 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:

N/A		

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 ☑

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 ☐

Are any of the owners health professionals? If yes, please 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.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☑

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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.

Casey Hoyt

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

CASEY HOYT

Print Name of Authorized Person

11/4/19

Date

Board Use Only	Received:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION LLC

State of Incorporation: Louisiana

Parent Company if any: Viemed Inc.

Corporation Name: Home Sleep Delivered, L.L.C.

Mailing Address: 625 E. Kaliste Saloom Road, Suite 200 S

City: Lafayette State: LA Zip: 70508

Telephone: (337) 857-3646 Fax: (337) 857-3514

Contact Person: Andrew Hill

For any corporation non-publicly traded, disclose the following:

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

a) Viemed Inc. 202 N. Luke St. Lafayette LA 70506
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

Include 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.

Client#: 1946454 518VIEMEINC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/08/2019

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Kristine LeBlanc CIC,CMIP,CISR	
McGriff Insurance Services 5750 Johnson Street 5th Floor Suite 505 Lafayette, LA 70503	PHONE (A/C, No, Ext): 337 314-8949	FAX (A/C, No): 337-234-0776
	E-MAIL ADDRESS: kristine.leblanc@mcgriffinsurance.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Benchmark Insurance Company	41394
INSURED Home Sleep Delivered, LLC 202-B N. Luke Street Lafayette, LA 70506	INSURER B : Travelers Indemnity Co of CT	25682
	INSURER C : Travelers Indemnity Company	25658
	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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			D1018G314013	08/01/2019	08/01/2020	EACH OCCURRENCE	$1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$5,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$3,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$3,000,000
	OTHER:							$
C	AUTOMOBILE LIABILITY			8105N822729	08/01/2019	08/01/2020	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB X OCCUR			UM101850236	08/01/2019	08/01/2020	EACH OCCURRENCE	$5,000,000
	X EXCESS LIAB CLAIMS-MADE						AGGREGATE	$5,000,000
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			UB1L76006A19I2G	08/01/2019	08/01/2020	X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N	N/A					E.L. EACH ACCIDENT	$1,000,000
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$1,000,000
A	Professional Liab			D1018G314013	08/01/2019	08/01/2020	Included in GL Limits	

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

(See Attached Descriptions)

CERTIFICATE HOLDER

Evidence of Coverage

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

William Quinlan

© 1988-2015 ACORD CORPORATION. All rights reserved.

DESCRIPTIONS (Continued from Page 1)

Schedule of Locations:
202-A N. Luke Street, Lafayette LA 70506
202-B N. Luke Street, Lafayette LA 70506
2426 Jake Drive, Suites 1, 2 & 3, Opelousas LA 70570
1192 Long Hollow Pike, Gallatin TN 37066
447 Call Road, Suites 211 & 212, Charleston WV 25312
1902 Corona Road, Suite 101, Columbia MO 65203
6605 Abercorn Street, Suites 107 D&E, Savannah GA 31405
8201 Ranch Boulevard, Suite B-1, Offices 1 & 8, Little Rock AR 72223
16903 Red Oak Drive, Suite 172C, Houston TX 77090
9726 E. 42nd Street, Suites 133 & 135, Tulsa OK 74146
1169 Eastern Parkway, Suite 1259, Louisville KY 40217
11801 N. Tatum Blvd, Suite 140, Phoenix AZ 85028
232 Market Street, Suites 247 & 249, Flowood MS 39232
720 S. Colorado Blvd., Penthouse North, Suite# 1375/1376, Denver CO 80246
11 North Water Street, Suite 10290, Unit #1066/1067, Mobile AL 36602
1414 Eraste Landry Road, Lafayette LA 70506
625 E. Kaliste Saloom Road, Lafayette LA 70508
200 S. Virginia, Suite 829, Reno NV 89501
1050 SW 6th Avenue, Suite 1100, Portland OR 97204
625 E. Kaliste Saloom Road, Suite 200S, Lafayette LA 70508

UNITED STATES OF AMERICA

State of Louisiana

R. Kyle Ardoin

SECRETARY OF STATE

As Secretary of State of the State of Louisiana, I do hereby Certify that

HOME SLEEP DELIVERED, L.L.C.

A limited liability company domiciled in LAFAYETTE, LOUISIANA,

Filed charter and qualified to do business in this State on February 05, 2010,

I further certify that the records of this Office indicate the company has paid all fees due the Secretary of State, and so far as the Office of the Secretary of State is concerned, is in good standing and is authorized to do business in this State.

I further certify that this certificate is not intended to reflect the financial condition of this company since this information is not available from the records of this Office.

In testimony whereof, I have hereunto set my hand and caused the Seal of my Office to be affixed at the City of Baton Rouge on,

October 28, 2019

Secretary of State

Web 40120162K

STATE OF LOUISIANA · UNION · JUSTICE · CONFIDENCE · SECRETARY OF STATE

Certificate ID: 11134117#C4C42

To validate this certificate, visit the following web site, go to **Business Services, Search for Louisiana Business Filings, Validate a Certificate**, then follow the instructions displayed.
www.sos.la.gov

Louisiana Board Of Pharmacy

Application for New Durable Medical Equipment (DME) Permit for

Home Sleep Delivered, L.L.C., FEIN – 27-1990310

Section 4: Company Ownership

Owner:
Viemed, Inc.

FEIN: 38-4052008
Address: 202 N. Luke St., Lafayette, LA 70506
Phone: 337-769-9611

100% owner

Key Management: *None of the officers listed below has held a professional license from any state licensing or regulatory authority.*

1) Casey Bryan Hoyt, CFO (and Viemed Managing Officer)
   SS#:
   DOB:
   Saddlewood Corner, Lafayette, LA 70508
   Business Phone: 337-504-3802

2) Michael Brandon Moore, President
   SS#:
   DOB:
   Mont De Marson Dr, Lafayette, LA 70507
   Business Phone: 337-504-3802

4U

11-12

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☐ Ownership Change
{Please provide current license number if making changes: MP or MV_____

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

FACILITY INFORMATION

Facility Name: Hospital Overstock LLC

Physical Address: 1160 S. Rogers Circle UNIT 3 Boca Raton, FL 33487
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1020 Holland Dr. STE 121

City: Boca Raton State: Florida Zip Code: 33487

Telephone: 561-999-3244 Fax: 561-994-9633

E-mail: dkula@hospitaloverstock.net Website: www.hospitaloverstock.net

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:30 to 5:00 Tue: 8:30 to 5:00 Wed: 8:30 to 5:00 Thu: 8:30 to 5:00

Fri: 8:30 to 5:00 Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Daniel Kula

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: _____

**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 OUT-OF-STATE 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:

None		

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 ☑

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 ☑

Are ciny of the owners health professionals? If yes, please 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.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☑

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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, pied 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 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

DANIEL KULA

Print Name of Authorized Person

11/8/19

Date

Board Use Only	Received: ------	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP 15 A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Florida

Parent Company if any: _____

Corporation Name: Hospital Overstock LLC

Mailing Address: 1020 Holland Dr. STE 121

City: Boca Raton State: Florida Zip: 33487

Telephone: 561-999-3244 Fax: 561-994-9633

Contact Person: Daniel Kula

For any corporation non publicly traded, disclose the following:

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

a) Daniel Kula (Name) 122 NW Gardner St. Boca Raton,FL 33432 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

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

3) What was the price paid per share? $10

4) What date did the corporation actually receive the cash assets? 6/19/09

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

Include 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.

Daniel Kula Managing Member

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP General -- Limited -X-

Partnership Name: Hospital Overstock LLC

Mailing Address: 1020 Holland Dr. STE 121

City: Boca Raton State: Florida Zip: 33487

Telephone: 561-999-3244 Fax: 561-994-9633

Contact Person: Daniel Kula

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
Daniel Kula	G	100%

List names of 4 largest partners and percentage of ownership:

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

State of Florida
Department of State

I certify from the records of this office that HOSPITAL OVERSTOCK LLC is a limited liability company organized under the laws of the State of Florida, filed on June 19, 2009.

The document number of this limited liability company is L09000059958.

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 18, 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 Twenty-fifth day of October, 2019

GREAT SEAL OF THE STATE OF FLORIDA
IN GOD WE TRUST

Secretary of State

Tracking Number: 2163782853CU

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

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

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/3/2019

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 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 Keyes Coverage Insurance 5900 Hiatus Road Tamarac FL 33321	CONTACT NAME: Michellita Swaney PHONE (A/C, No, Ext): 954-724-7000 FAX (A/C, No): 924-724-7024 E-MAIL ADDRESS: mswaney@keyescoverage.com
INSURED 11760 Hospital Overstock LLC Daniel Kula 1020 Holland Drive Ste 121 Boca Raton FL 33487	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Hanover Insurance Company — 22292 INSURER B : Massachusetts Bay Ins Co — -22306 INSURER C : Zenith Insurance Co. — 13269 INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 1690313471 **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	
B	X COMMERCIAL GENERAL LIABILITY	Y		RDJ 9908326-06	4/14/2019	4/14/2020	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER						GENERAL AGGREGATE	$ 3,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR			UHJ 9908688 06	4/14/2019	4/14/2020	EACH OCCURRENCE	$ 4,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ 4,000,000
	DED RETENTION $							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			Z127023305	2/13/2019	2/13/2020	X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N / N/A (Mandatory in NH)						E L EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E L DISEASE - EA EMPLOYEE	$ 500,000
							E L DISEASE - POLICY LIMIT	$ 500,000

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

Leased Premises: 1020 Holland Drive Ste 121, Boca Raton, FL 33487 (Daniel Kula)
Holland Drive Industrial Park, LTD and Danburg Management Corporation are Additional Insured with regards to the above leased premises.

CERTIFICATE HOLDER

Holland Drive Industrial Park, LTD.
Danburg Management Corporation
7700 Congress Avenue, Suite 3100
Boca Raton FL 33487

CANCELLATION 30 Days Notice/10 Days for Non-Pay

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

© 1988-2014 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

OPERATING AGREEMENT
OF
HOSPITAL OVERSTOCK, LLC

This Operating Agreement of HOSPITAL OVERSTOCK, LLC, (the "Company") is entered into effective for all purposes as of June 19, 2009, by DANIEL KULA, as the initial Member.

ARTICLE I
INTRODUCTION

1.1 Formation of Limited Liability Company. The Company has been formed by filing Articles of Organization (the "Articles") with the Department of the Secretary of State of Florida. This Operating Agreement is subject to, and governed by, the Act and the Articles. In the event of a conflict between the provisions of this Operating Agreement and the mandatory provisions of the Act or the provisions of the Articles, such provisions of the Act or the Articles, as the case may be, are controlling.

1.2 Defined Terms. The following terms used in this Operating Agreement with their initial letters capitalized, unless the context requires otherwise or unless otherwise expressly provided in this Operating Agreement, have the meanings specified in this Section 1.2. The singular includes the plural and vice versa, as the context requires.

(a) "Act" means the Florida Limited Liability Company Act, as it may be amended from time to time.

(b) "Additional Member" means any individual or Entity admitted as a Member pursuant to Section 2.7 of this Operating Agreement.

(c) "Affiliate" means any individual or Entity which, directly or indirectly, or through one or more intermediaries, controls, is controlled by, or is under common control with a Member. The term "control," as used in the immediately preceding sentence, means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of the controlled Entity.

(d) "Bankruptcy" means, and a Member shall be deemed a "Bankrupt Member" on (i) the entry of a decree or order for relief against the Member by a court of competent jurisdiction in any involuntary case brought against the Member under any bankruptcy, insolvency, or other similar law (collectively, "Debtor Relief Laws") generally affecting the rights of creditors and relief of debtors now or hereafter in effect, (ii) the appointment of a receiver, liquidator, assignee, custodian, trustee, sequestrator or other similar agent under applicable Debtor Relief Laws for the Member or for any substantial part of its assets or property, (iii) the ordering of the winding up or liquidation of the Member's affairs, (iv) the filing of a petition in any such involuntary bankruptcy case that remains undismissed or suspended pursuant to Section 305 of the Federal Bankruptcy Code (or any corresponding provision of any future United States bankruptcy law), (v)

HOSPITAL OVERSTOCK, LLC

EXHIBIT "A" TO OPERATING AGREEMENT

Members/ Addresses	Capital Contribution	Percentage Interest
DANIEL KULA [redacted] NW Gardner St. Boca Raton,FL 33432	$100	100%
Total	$100	100%

4V

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**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

(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4

☒ Non Publicly Traded Corporation – Pages 1,2,3,5

☐ 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.

FACILITY INFORMATION

Facility Name: MEDICO INTERNACIONAL, LLC

Physical Address: 3400 SW 20 STREET, PEMBROKE PARK, FL 33023

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

Mailing Address: 4150 NW 93 AVENUE

City: GAINESVILLE State: FL Zip Code: 32653

Telephone: 305-405-6169 Fax: _____

E-mail: KELLEY.FINLEN@MEDICOINTERNACIONAL.COM Website: WWW.MEDICOINTERNACIONAL.COM

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 6am to 10pm Tue: 6am to 10pm Wed: 6am to 10pm Thu: 6am to 10pm Fri: 6am to 10pm Sat: 7Am to 12pm Sun: – to – Holidays: – to –

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: JESSE OPPENHEIMER

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: DISPOSABLE MEDICAL SUPPLIES

**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 OUT-OF-STATE 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:

N/A		

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 ☒

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 ☐

Are any of the owners health professionals? If yes, please list name.

- Practitioner — Name: _____
- Advanced Practitioner of Nursing — Name: _____
- Physician's Assistant — Name: _____
- Physical Therapist — Name: N/A
- Occupational Therapist — Name: _____
- Registered Nurse — Name: _____
- Respiratory Therapist — Name: _____

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

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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.

Kelley Finlen

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

KELLEY FINLEN

Print Name of Authorized Person

12/5/19

Date

Board Use Only	Received:_____	Amount: _____

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: FLORIDA

Parent Company if any: _____

Corporation Name: MEDICO INTERNACIONAL, LLC

Mailing Address: 4150 NW 93 AVENUE

City: GAINESVILLE State: FL Zip: 32653

Telephone: 305-405-6169 Fax: _____

Contact Person: JESSE OPPENHEIMER

For any corporation non-publicly traded, disclose the following:

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

a) DAVID P. FRANK 3400 SW 20th STREET, PEMBROKE PARK, FL 33023
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

Include 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.

Medico Internacional, LLC list of Officers and Directors:

Owner: David Frank

Manager: Harvey Budd

ACORD

MEDIC-4

OP ID: SF

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/19/2019

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
TCC Associates, Inc.
PO Box 11975
Fort Lauderdale, FL 33339-1975
Thomas C Cundy, Jr.
954-565-1117

CONTACT NAME: Thomas C Cundy, Jr.
PHONE (A/C, No, Ext): 954-565-1117 FAX (A/C, No): 954-565-1131
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Burlington	
INSURER B: North River Insurance Company	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Medico Internacional, LLC
The Glove Store, LLC
3400 S.W. 20th Street
Pembroke Park, FL 33023

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			604BW51547	05/03/2019	05/03/2020	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 1,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	$ 2,000,000
	POLICY PRO-JECT LOC						GENERAL AGGREGATE	$ 2,000,000
	OTHER						PRODUCTS - COMP/OP AGG	$ 2,000,000
	AUTOMOBILE LIABILITY							$
	ANY AUTO						COMBINED SINGLE LIMIT (Ea accident)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per person)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
B	UMBRELLA LIAB X OCCUR							
	X EXCESS LIAB CLAIMS-MADE			5821121736	05/03/2019	05/03/2020	EACH OCCURRENCE	$ 8,000,000
	DED RETENTION $						AGGREGATE	$ 8,000,000
							Prod/Comp	$ 8,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N N/A						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						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)
Medical Supplies

CERTIFICATE HOLDER

FORINFO

For Informational Purposes

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

ACORD 25 (2016/03)

© 1988-2015 ACORD CORPORATION. All rights reserved.
The ACORD name and logo are registered marks of ACORD

State of Florida
Department of State

I certify from the records of this office that MEDICO INTERNACIONAL, LLC is a limited liability company organized under the laws of the State of Florida, filed on January 19, 2006.

The document number of this limited liability company is L06000006895.

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 February 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 Seventeenth day of December, 2019



Secretary of State

Tracking Number: 7829691575CU

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

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

4W

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**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
(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 1,2,3,5 ☑ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Midland Mobility & Surgical Supply, LLC

Physical Address: 800 Midland Avenue Thomasville, NC
(This must be a business address, we cannot issue a license to a home address)

Mailing Address: 800 Midland Avenue

City: Thomasville State: NC Zip Code: 27360

Telephone: 855 481-9150 Fax: 336-481-9133

E-mail: jasonherlocker@gmail 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 3 Fri: _____ to _____

Sat: _____ to _____ Sun: _____ to _____ Holidays: _____ to _____

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Jason F. Herlocker

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: _____

**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 OUT-OF-STATE 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:

104 371 2219 _____ _____

_____ _____ _____

_____ _____ _____

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 ☒

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 ☐

Are any of the owners health professionals? If yes, please 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.

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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

Jason Herlocker
Print Name of Authorized Person

12-11-19
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

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

Owner's Name: Jason Herlocker

List all previous names: _____

Social Security Number: [redacted]

Date of Birth: [redacted]

Place of Birth: City: Greensboro State: NC Country: USA

Citizenship: USA ✓ other _____

If applicable, list Naturalization Number: _____ Passport Number: _____

Current residence address: [redacted] N. Old Greensboro Rd City: High Point

State: NC Zip Code: 27265 Telephone Number: _____ Fax Number: _____

Previous address (last 5 years):

Address: _____ City: _____ State: Zip Code: _____

Address: 4007 Tanback Ct. City: Greensboro State: NC Zip Code: 27408

Address: _____ City: _____ State: Zip Code: _____

Address: _____ City: _____ State: Zip Code: _____

Business Name: Midland Mobility + Surgical Supply

Current Business Address: 800 Midland Ave

City: Thomasville State: NC Zip Code: 27360

Telephone Number: 855 481 9150 Fax Number: 336 481 - 9133

Previous Employment (last 5 years):

Name: Once Upon A Child Address: 6011 Poyner Village Pkwy

City: Raleigh State: NC Zip Code: 27608

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/07/2019

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 Good Deeds Insurance 6285 Shallowford Road, Ste 150 Lewisville, NC 27023	CONTACT NAME: Zach Manning PHONE (A/C, No, Ext): 336-564-2418 FAX (A/C, No): 336-232-1758 E-MAIL ADDRESS: zach@gooddeedsinsurance.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Bankers Insurance Company	
INSURED Midland Mobility & Surgical Supply LLC 800 Midland Ave Thomasville NC 27360	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:			32 0004933907 1 0	03/26/2019	03/26/2020	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 2,000,000
							GENERAL AGGREGATE	$ 4,000,000
							PRODUCTS - COMP/OP AGG	$ 4,000,000
								$
	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 ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐ N / A If yes, describe under DESCRIPTION OF OPERATIONS below						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

BOC
10461 Mill Run Circle
Ste 1250
Owings Mills, MD 21117

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

Zach Manning

© 1988-2016 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

North Carolina Board of Pharmacy

License Verification

Only the top 250 records are shown

This serves as Primary Source Verification of the credential issued by the North Carolina Board of Pharmacy

Name:

Midland Mobility & Surgical Supply LLC

Permit Number:

02695

Address:

800 Midland Ave

Permit Status:

Active

City:

Thomasville

Issue Date:

09/16/2019

State/Zip:

NC 27360

Expire Date:

12/31/2020

Person in Charge:

Jason Forest Herlocker

Discipline:

No

4X

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**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
(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 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: New Britain Medical Supplies

Physical Address: 74 Vine Street, Fl 3
(This must be a business address, we cannot issue a license to a home address)

Mailing Address: 74 Vine Street, Fl 3

City: New Britain State: CT Zip Code: 06052

Telephone: 860-224-9017 Fax: 860-223-1658

E-mail: heidi.taylor@wellspect.com Website: newbritainmedicalsupplies.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:30 to 5 Tue: 8:30 to 5 Wed: 8:30 to 5 Thu: 8:30 to 5 Fri: 8:30 to 5 Sat: - to - Sun: - to - Holidays: - to -

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Sarah McMillan

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: Continence, incontinence + Ostomy

**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 OUT-OF-STATE 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:

605427001	0042460 22	
Medicare	CT medicaid	

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 ☑

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 ☑

Are any of the owners health professionals? If yes, please 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.

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☑

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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

Eric Hymes
Print Name of Authorized Person

12/02/2019
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Connecticut

Parent Company if any: _____

Corporation Name: New Britain Medical Supplies

Mailing Address: 74 Vine Street Fl 3

City: New Britain State: CT Zip: 06052

Telephone: 860-224-9017 Fax: 860-223-1658

Contact Person: Heidi Taylor

For any corporation non-publicly traded, disclose the following:

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

a) none
Name Address

b) none
Name Address

c) none
Name Address

d) none
Name Address

2) Provide the number of shares issued by the corporation. 0

3) What was the price paid per share? n/a

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

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

Include 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.

Secretary of The State of Connecticut

I, the Secretary of The State of Connecticut, and keeper of the seal thereof, DO HEREBY CERTIFY, that the certificate of incorporation of

NEW BRITAIN MEDICAL SUPPLIES, INC.

a domestic STOCK corporation, was filed in this office on July 11, 2006, a certificate of dissolution has not been filed, the corporation has filed all annual reports, and so far as indicated by the records of this office such corporation is in existence.

Secretary of The State of Connecticut

Date Issued: November 15, 2019

Business ID: 0866037 Express Certificate Number: 2019426779001

Note: To verify this certificate, visit the web site http://www.concord.sots.ct.gov

New Britain
Medical Supplies
Specializing in Urology
www.newbritainmedicalsupplies.com
74 Vine Street, New Britain, CT 06052 | Office: 860.224.9017 Fax: 860-223-1658
| Toll Free: 855.332.0285

New Britain Medical Supplies Officers

Svenn Poulsen, President (svenn.poulsen@wellspect.com)
Eric Hymes, Vice President (eric.hymes@wellspect.com)
Robert J. Winters, Vice President (bob.winters@dentsplysirona.com)
Justin H. McCarthy II, Secretary (Justin.mccarthy@dentsplysirona.com)
William E. Reardon, Treasurer (william.reardon@dentsplysirona.com)

Mailing Address:

590 Lincoln Street
Waltham, MA 02451
(P) 877.456.3742

REEVE FOUNDATION PEER & FAMILY SUPPORT PROGRAM

Accredited by
Joint Commission

mtg Rochester BARD Coloplast Hollister

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

CUSTOMER NUMBER: 0007040401

DATE (MM/DD/YYYY) 08/24/19

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:
PHARMACISTS MUTUAL INSURANCE COMPANY 808 HIGHWAY 18 WEST, PO BOX 370 ALGONA, IA 50511-0370	PHONE (A/C, No. Ext): 800-247-5930 FAX (A/C, No): E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Pharmacists Mutual Insurance Company	13714
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED

NEW BRITAIN MEDICAL SUPPLIES INC
74 VINE ST FL 3
NEW BRITAIN CT 06052-1431

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			BOP 0095649 12 Includes- Health Care Consultation Services Liability	11/15/2019	11/15/2020	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ INCLUDED
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
							WATER LEGAL LIABILITY	$ 50,000
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS						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 DESCRIPTIONS OF OPERATIONS below	N/A						PER STATUTE [ ] OTHER	
							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)

See Remarks for Location Schedule

CERTIFICATE HOLDER

FOR EVIDENCE 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
GAIL T. WOLFE, CISR, API

© 1988-2015 ACORD CORPORATION. All rights reserved.

AGENCY CUSTOMER ID: 0007040401

LOC #:

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
	NEW BRITAIN MEDICAL SUPPLIES I 74 VINE ST FL 3 NEW BRITAIN CT 06052-1431
POLICY NUMBER BOP 0095649 12	
CARRIER: Pharmacists Mutual / NAIC CODE: 13714	EFFECTIVE DATE: 11/15/19

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM

FORM NUMBER: Acord25 FORM TITLE: EVIDENCE OF COMMERCIAL LIABILITY INSURANCE

LOCATION SCHEDULE

Loc. 001 Bldg. 001
74 VINE ST FL 3
NEW BRITAIN, CT 06052-1431

2008 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

4Y

NEVADA STATE BOARD OF PHARMACY

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 MP00582)

☐ 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: National Seating & Mobility, Inc.

Physical Address: 6553 South Cottonwood St Murray, UT 84107-6981

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

Mailing Address: 5959 Shallowford Rd Ste 443

City: Chattanooga State: TN Zip Code: 37421-2245

Telephone: (Phys) 801-281-6601 (Mail) 423-756-2268 Fax: (Phys) 877-263-9918 (Mail) 423-362-5413

(Phys) saltlakecity@nsm-seating.com (Mail) NSMWest@nsm=seating.com

E-mail: _____ Website: www.nsm-seating.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 8am to 5pm Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: _____

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: DME/CRT

**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:

See Attached	See Attached	See Attached

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.

N/A

☐ 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.

Within the last five (5) years:

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 ☒

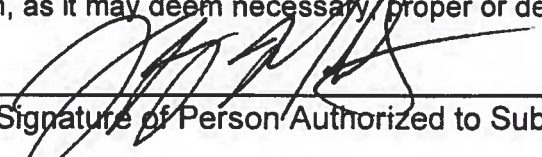
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Jeffrey Matukewicz
Print Name of Authorized Person

12/9/2019
Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: TN

Parent Company if any: _____

Corporation Name: National Seating & Mobility, Inc.

Mailing Address: 5959 Shallowford Rd Ste 443

City: Chattanooga State: TN Zip: 37421-2245

Telephone: 423-756-2268 Fax: 423-362-5413

Contact Person: Stephanie Baggett

For any corporation non publicly traded, disclose the following:

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

a) _____
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses.*

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

3) What was the price paid per share? _____

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

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

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

1/31/2017

DATE (MM/DD/YYYY) 10/27/2016

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	Lockton Companies 8110 E. Union Avenue Suite 700 Denver CO 80237 (303) 414-6000
CONTACT NAME:	
PHONE (A/C, No, Ext):	FAX (A/C, No):
E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Fire and Marine Insurance Co	20079
INSURER B : New Hampshire Indemnity Company, Inc.	23833
INSURER C : Granite State Insurance Company	23809
INSURER D : New Hampshire Insurance Company	23841
INSURER E : Insurance Company of the State of PA	19429
INSURER F :	

INSURED 1418818 National Seating & Mobility, 5959 Shallowford Road, Suite 443, Chattanooga, TN 37421

COVERAGES **CERTIFICATE NUMBER: 14351439** **REVISION NUMBER: XXXXXXX**

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	N	N	42-GLO-100396-02	10/31/2015	1/31/2017	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X Prof Liability						MED EXP (Any one person)	$ XXXXXXX
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	$ 1,000,000
	POLICY [ ] PRO-JECT [ ] LOC						GENERAL AGGREGATE	$ 2,000,000
	OTHER						PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
B	AUTOMOBILE LIABILITY	N	N	2305047 (AOS)	10/31/2016	1/31/2017	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
C	X ANY AUTO			2305050 (MA)	10/31/2016	1/31/2017	BODILY INJURY (Per person)	$ XXXXXXX
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$ XXXXXXX
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$ XXXXXXX
								$ XXXXXXX
A	X UMBRELLA LIAB X OCCUR	N	N	42-UMO-100397-02	10/31/2015	1/31/2017	EACH OCCURRENCE	$ 5,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ 5,000,000
	DED RETENTION $							$ XXXXXXX
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N		N	12852207(AOS)	10/31/2016	1/31/2017	X PER STATUTE OTH-ER	
E	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A		12852208 (CA)	10/31/2016	1/31/2017	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Location #88 Vegas – 7665 Commercial Way, Ste H, Henderson NV 89011

OCT 31 2016

CERTIFICATE HOLDER

14351439

Nevada State Board of Pharmacy
431 W Plumb Ln
Reno NV 89509

CANCELLATION See Attachments

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

Charles M. McDaniel

ACORD 25 (2016/03)

©1988-2015 ACORD CORPORATION. All rights reserved
The ACORD name and logo are registered marks of ACORD

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

TRICIA H PAGE
STE #443
5959 SHALLOWFORD RD
CHATTANOOGA, TN 37421

December 19, 2012

Request Type: Certificate of Existence/Authorization
Request #: 0085514

Issuance Date: 12/19/2012
Copies Requested: 1

Document Receipt

Receipt # : 862666 — Filing Fee: $22.25

Payment-Credit Card - TennesseeAnytime Online Payment #: 148161510 — $22.25

Regarding: **NATIONAL SEATING & MOBILITY, INC.**
Filing Type: Corporation For-Profit - Domestic
Formation/Qualification Date: 05/10/1989
Status: Active
Duration Term: Perpetual
Business County: HAMILTON COUNTY

Control # : 215678
Date Formed: 05/10/1989
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

NATIONAL SEATING & MOBILITY, INC.

* is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent corporation annual report required with this office;

* has appointed a registered agent and registered office in this State;

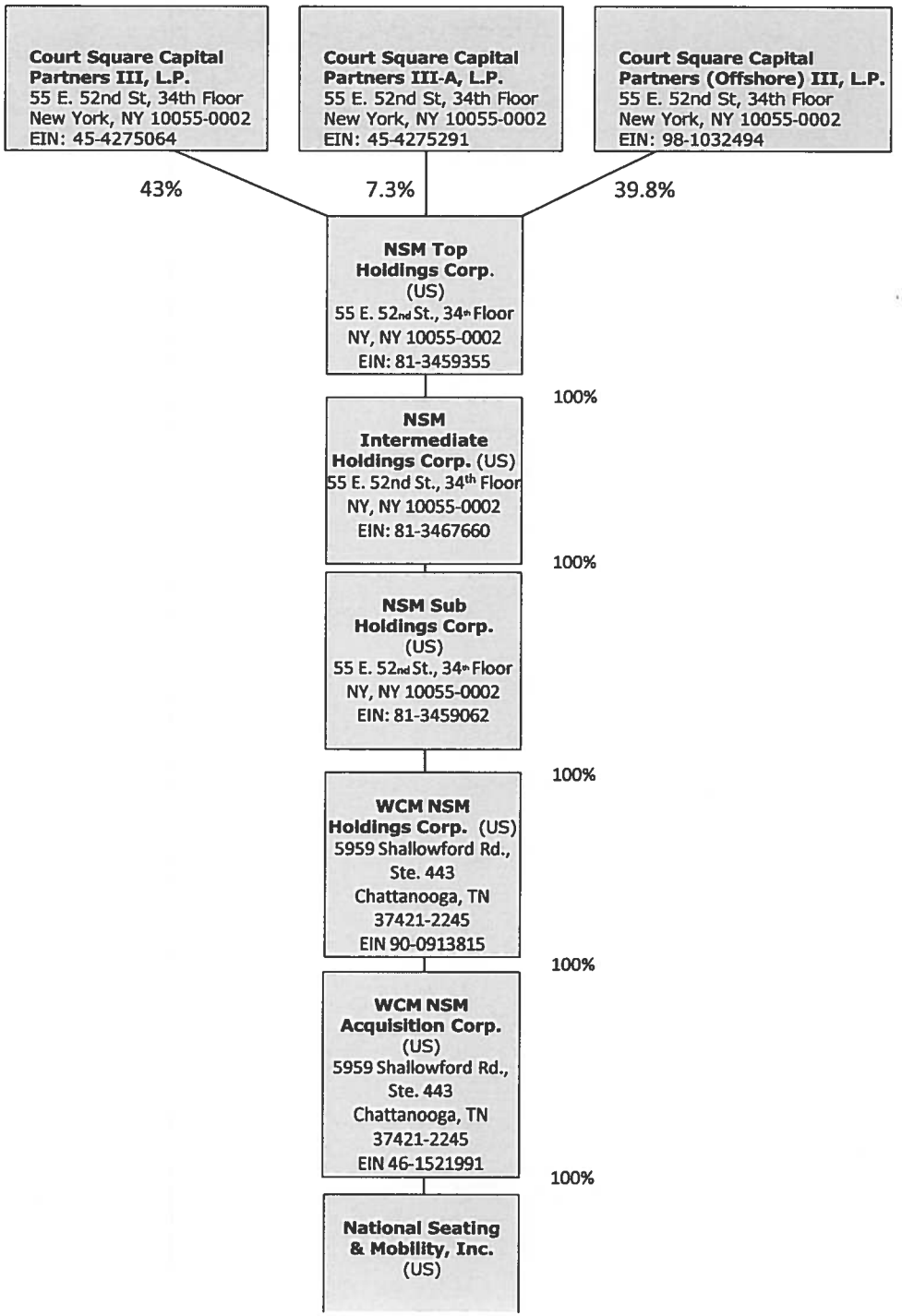
* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

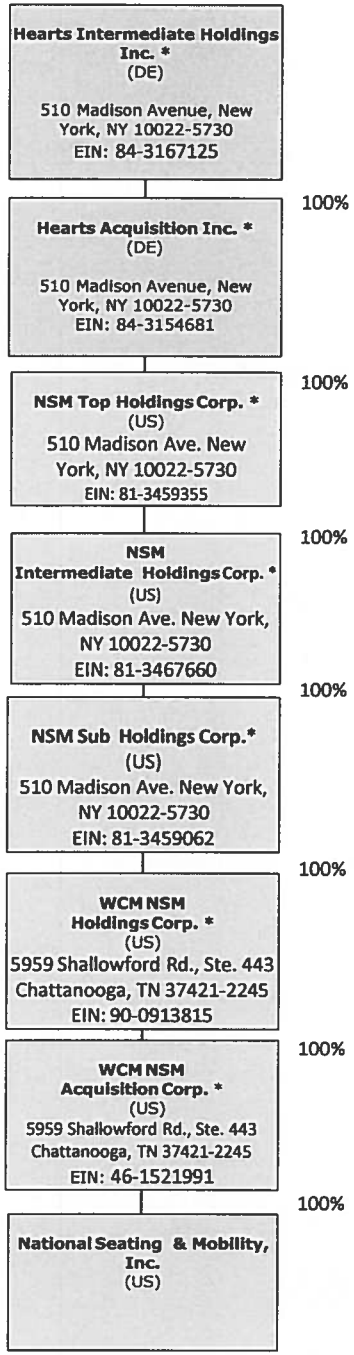
Processed By: Cert Web User

Verification #: 002228217

Pre-Close Legal Entity Structure



Post-Close Legal Entity Structure



* Entity may be converted to LLC following the close but will maintain the same FEIN and business address

Branch #	Branch Name	TaxId	NPI	ProviderName	Branch Address	Branch City	Branch State	Zip Code	Medicare ID	Medicaid ID
02	Birmingham	62-1400785	1548235260	National Seating & Mobility, Inc.	2521 MeadowView Lane Suite D	Pelham	AL	35124-4343	0570710003	000057245
03	Miami	62-1400785	1174596019	National Seating & Mobility, Inc.	1335 NW 98th Court Unit 1	Doral	FL	33172-2777	0570710004	029905700
04	Houston	62-1400785	1477526333	National Seating & Mobility, Inc.	9494 Kirby Drive	Houston	TX	77054-3905	570710006	016241404
05	Atlanta	62-1400785	1770556623	National Seating & Mobility, Inc.	3417 Oakcliff Road, STE 106	Doraville	GA	30340-3004	0570710002	000521595A
07	Arlington	62-1400785	1891768735	National Seating & Mobility, Inc.	2300 Valley View Lane, STE 205	Farmers Branch	TX	75234-5737	570710005	009921006
08	Chatsworth	62-1400785	1053384990	National Seating & Mobility, Inc.	21807 Plummer Street	Chatsworth	CA	91311-4110	570710008	1053384990
11	Anaheim	62-1400785	1235102179	National Seating & Mobility, Inc.	1125 East Stanford Court	Anaheim	CA	92805-6822	570710011	1235102179
13	Mobile	62-1400785	1558334474	National Seating & Mobility, Inc.	854 Lakeside Drive Suite B	Mobile	AL	36606-2034	0570710075	009507090
16	Chicago	62-1400785	1003889684	National Seating & Mobility, Inc.	5444 East Ave Unit A	Countryside	IL	60525-3671	0570710020	621400785001
18	Stockton	62-1400785	1194799635	National Seating & Mobility, Inc.	4515 South B Street	Stockton	CA	95206-3956	570710019	1194799635
19	San Jose	62-1400785	1376516922	National Seating & Mobility, Inc.	1190 Dell Ave., Unit L	Campbell	CA	95008-6614	570710016	1376516922
20	Evansville	62-1400785	1265405104	National Seating & Mobility, Inc.	2626 Kotter Ave., STE C	Evansville	IN	47715-8530	0570710018	100194330C
22	Hayward	62-1400785	10533384982	National Seating & Mobility, Inc.	2462 Tripaldi Way	Hayward	CA	94545-5017	570710026	1053384982
23	Milwaukee	62-1400785	1972576528	National Seating & Mobility, Inc.	12020 W. Feerick St Ste A	Wauwatosa	WI	53222-2120	0570710024	1972576528
24	Madison	62-1400785	1013980945	National Seating & Mobility, Inc.	726 Walsh Rd	Madison	WI	53714-1370	0570710023	1013980945
25	San Diego	62-1400785	1356314900	National Seating & Mobility, Inc.	7945 Dunbrook Rd. Suite F&G	San Diego	CA	92126-6323	570710026	1356314900
26	Bakersfield	62-1400785	1790758340	National Seating & Mobility, Inc.	4705 New Horizon Blvd., Ste. 2	Bakersfield	CA	93313-2369	570710027	1790758340
28	Toledo	62-1400785	1881667434	National Seating & Mobility, Inc.	6501 Angola Road Unit P	Holland	OH	43528-9651	0570710029	2058464
29	Greenville	62-1400785	1427021369	National Seating & Mobility, Inc.	153 Grace Dr. Unit A	Easley	SC	29640-9088	570710032	DE1262
30	Montgomery	62-1400785	1508839432	National Seating & Mobility, Inc.	1406 I-85 Parkway	Montgomery	AL	36106-2813	0570710031	009814350
33	Troy	62-1400785	1891768719	National Seating & Mobility, Inc.	1967 Woodslee Drive	Troy	MI	48083-2236	0570710035	1891768719
34	Lexington	62-1400785	1205809126	National Seating & Mobility, Inc.	2025 Leestown Rd. Unit L	Lexington	KY	40511-1000	570710036	90001470
36	Fresno	62-1400785	1538132444	National Seating & Mobility, Inc.	4980 E. University Ave., Unit 114	Fresno	CA	93727-1659	570710042	1538132444
38	Sacramento	62-1400785	1225001894	National Seating & Mobility, Inc.	3651 Buisness Dr. STE 120	Sacramento	CA	95820-2176	570710043	1225001894
39	Santa Rosa	62-1400785	1982677530	National Seating & Mobility, Inc.	3535 Industrial Drive Suite B1	Santa Rosa	CA	95403-2039	570710040	1982677530
40	Fairfield	62-1400785	1265405815	National Seating & Mobility, Inc.	2850 Cordelia Rd. Ste. 150	Fairfield	CA	94534-1655	570710044	1265405815
45	Philadelphia	62-1400785	1326011263	National Seating & Mobility, Inc.	1957 Pioneer Road, BLDG C	Huntingdon Valley	PA	19006-2503	570710045	1007304120017

47	Natick	62-1400785	1679546519	National Seating & Mobility, Inc.	8 Erie Drive Unit A	Natick	MA	01760-1313	570710046	110028194a
48	Memphis	62-1400785	1932172871	National Seating & Mobility, Inc.	3930 South Perkins Road	Memphis	TN	38118-7029	570710053	1454087
49	Little Rock	62-1400785	1417920067	National Seating & Mobility, Inc.	7123 Interstate 30 Suite 13	Little Rock	AR	72209-3165	0570710047	140980716
50	Fort Smith	62-1400785	1043283963	National Seating & Mobility, Inc.	6901 Dallas Street Ste. A	Fort Smith	AR	72903-5037	0570710048	1043283963
52	Champaign	62-1400785	1467425017	National Seating & Mobility, Inc.	3808 W. Springfield Ave. Suite B	Champaign	IL	61822-8806	0570710054	621400785-006
53	Peoria	62-1400785	1932172848	National Seating & Mobility, Inc.	4209 Pfieffer Rd	Bartonville	IL	61607-2812	0570710055	621400785-005
54	Charleston, WV	62-1400785	1124091038	National Seating & Mobility, Inc.	200 Roxalana Business Park	Dunbar	WV	25064-2727	570710056	WV - 6203054000 KY - 7100275600 KY - 7100298740 OH - 0087013
57	Buffalo	62-1400785	1003889940	National Seating & Mobility, Inc.	198 Ransier Drive	West Seneca	NY	14224-2259	570710059	02527228
58	Wichita	62-1400785	1205809860	National Seating & Mobility, Inc.	1635 East 37th Street North Ste. 5	Wichita	KS	67219-3557	570710061	200253730A
59	Connecticut	62-1400785	1659344505	National Seating & Mobility, Inc.	11 Freedom Way A3-A6	Niantic	CT	06357-1041	570710060	004240339
60	Honolulu	62-1400785	1184699209	National Seating & Mobility, Inc.	96-1173 Waihona Street Ste A3	Pearl City	HI	96782-1931	570710062	55561701
61	Fort Wayne	62-1400785	1497728331	National Seating & Mobility, Inc.	3927 Kraft Pkwy Ste A	Ft. Wayne	IN	46825-4444	0570710021	100194330D
65	Chicopee	62-1400785	1841263621	National Seating & Mobility, Inc.	150 Padgette St. Unit F	Chicopee	MA	01022-1333	570710066	1100281948
68	Nashville	62-1400785	1598812232	National Seating & Mobility, Inc.	1610 Elm Hill Pike, Suite A	Nashville	TN	37210-3625	570710070	1455201
70	Redlands	62-1400785	1558428979	National Seating & Mobility, Inc.	350 Alabama St. Suites C,D & E	Redlands	CA	92373-8098	570710073	1558428979
71	Phoenix	62-1400785	1740347129	National Seating & Mobility, Inc.	8550 N. 91st Ave. Suite 79	Peoria	AZ	85345-8368	570710069	832341
72	San Antonio	62-1400785	1518174242	National Seating & Mobility, Inc.	8666 Huebner RD STE 100	San Antonio	TX	78240-1844	570710072	192883005
75	Orlando	62-1400785	1124218672	National Seating & Mobility, Inc.	715 West SR 434, STE Q	Longwood	FL	32750-4937	0570710076	003494000
76	Austin	62-1400785	1811183288	National Seating & Mobility, Inc.	2211 Denton Drive Suites GJ&L	Austin	TX	78758-4532	570710074	195210304
77	Salt Lake City	62-1400785	1710149299	National Seating & Mobility, Inc.	6553 South Cottonwood Street	Murray	UT	84107-6981	570710077	1710149299
79	Lafayette	62-1400785	1235381575	National Seating & Mobility, Inc.	207 Roto Park Drive	Broussard	LA	70518-4355	0570710080	1807981
80	New Orleans	62-1400785	1639322316	National Seating & Mobility, Inc.	5515 Pepsi St. Ste. A/B	Harrahan	LA	70123-3272	0570710085	1808016
82	Beaumont	62-1400785	1932347606	National Seating & Mobility, Inc.	10945 Eastex Freeway	Beaumont	TX	77708-0902	570710081	219171003
84	Louisville	62-1400785	1730327883	National Seating & Mobility, Inc.	11003 Bluegrass Parkway, Suite 460	Louisville	KY	40299-2392	570710078	7100101240
85	Ogden	62-1400785	1184863060	National Seating & Mobility, Inc.	1719 West 2800 South #102	Ogden	UT	84401-3263	570710084	1184863060
87	Columbus	62-1400785	1144458209	National Seating & Mobility, Inc.	306 E. 5th Ave	Columbus	OH	43201-2820	0570710087	3032800

88	Las Vegas	62-1400785	1154635878	National Seating & Mobility, Inc.	7665 Commercial Way, Suite H	Henderson	NV	89011-4084	570710089	1154635878
89	Minneapolis	62-1400785	1013224112	National Seating & Mobility, Inc.	1775 Old Highway 8 NW Ste 103	New Brighton	MN	55112-1891	0570710088	1013224112
91	McAllen	62-1400785	1225333099	National Seating & Mobility, Inc.	1201 W. Houston Avenue	McAllen	TX	78501-5012	570710090	285803705
92	Appleton	62-1400785	1508153370	National Seating & Mobility, Inc.	N922 Tower View Drive Unit N	Greenville	WI	54942-8097	0570710092	1508153370
94	Asheville	62-1400785	1649551474	National Seating & Mobility, Inc.	65 Shiloh Rd.	Asheville	NC	28803-2929	570710093	7705396
96	Billings	62-1400785	1740538883	National Seating & Mobility, Inc.	2747 Enterprise Ave.Ste. 4	Billings	MT	59102-7412	570710095	1740538883
97	Denver	62-1400785	1407198047	National Seating & Mobility, Inc.	12503 E. Euclid Dr. Ste. 60	Centennial	CO	80111-6400	570710096	08003717
98	Norfolk	62-1400785	1013351998	National Seating & Mobility, Inc.	3347 Enterprise Rd	Norfolk	VA	23502-1912	570710098	1013351998
99	Richmond	62-1400785	1710321690	National Seating & Mobility, Inc.	3941 Deep Rock Road	Richmond	VA	23233-1474	570710099	1710321690
101	Fisherville	62-1400785	1417391392	National Seating & Mobility, Inc.	88 Ivy Ridge Lane	Fishersville	VA	22939-3421	570710102	1417391392
103	Roanoke	62-1400785	1699114884	National Seating & Mobility, Inc.	5306 Peters Creek Rd. Ste. D.	Roanoke	VA	24019-3874	570710101	1699114884
105	Valdese	62-1400785	1821423229	National Seating & Mobility, Inc.	1031 Malcolm Blvd	Connelly Springs	NC	28612-7923	570710104	1821423229
106	Albany	62-1400785	1902232390	National Seating & Mobility, Inc.	12 Jupiter Lane, Unit 4	Albany	NY	12205-6918	570710103	03841967
107	Charlotte, NC	62-1400785	1740603075	National Seating & Mobility, Inc.	800 Central Ave.	Charlotte	NC	28204-2026	570710105	1740603075
108	Charleston, SC	62-1400785	1730504630	National Seating & Mobility, Inc.	2551 Oscar Johnson Drive. Suite C	North Charleston	SC	29405-6884	570710108	DE3533
109	New Jersey	62-1400785	1891113346	National Seating & Mobility, Inc.	5146 W. Hurley Pond Road	Wall Township	NJ	07727-1620	570710107	Out of Network
110	Jackson, MS	62-1400785	1295153674	National Seating & Mobility, Inc.	108 North Layfair Drive	Flowood	MS	39232-9782	0570710106	05826572
111	Providence, RI	62-1400785	1275947053	National Seating & Mobility, Inc.	11 Knight Street Unit F22-F23	Warwick	RI	02886-1397	570710109	1275947053
112	Oklahoma City	62-1400785	1982012951	National Seating & Mobility, Inc.	3500 S. Lakeside Drive	Oklahoma City	OK	73179-8400	570710111	100794550 D
113	Pittsburgh	62-1400785	1043619505	National Seating & Mobility, Inc.	730 Vista Park Ave	Pittsburgh	PA	15205-1214	570710110	1007304120019
115	Youngstown	62-1400785	1689078701	National Seating & Mobility, Inc.	1087 N. Meridian Rd.	Youngstown	OH	44509-1016	0570710113	0121640
116	Cleveland	62-1400785	1538556360	National Seating & Mobility, Inc.	6430 Eastland Rd	Brook Park	OH	44142-1340	0570710119	0152992
117	Hudson	06-1026214	1922285741	Hudson Home Health Care, Inc.	315 Derry Road, Unit 4 & 5	Hudson	NH	03051-3050	396640007	3076664
118	Fairfield	06-1026214	1730407768	Hudson Home Health Care, Inc.	1 Frassetto Way, Suite I	Lincoln Park	NJ	07035-2056	396640010	0195553
119	Plainview	06-1026214	1003052598	Hudson Home Health Care, Inc.	101 Fairchild Ave, Suite 2	Planview	NY	11803-1725	396640009	03161502
122	Woburn	06-1026214	1962470112	Hudson Home Health Care, Inc.	470 Wildwood Ave, Suite 4	Woburn	MA	01801-2082	396640005	110029302B
123	Franklin, MA	06-1026214	1750332797	Hudson Home Health Care, Inc.	101 Constitution Blvd Ste E	Franklin	MA	02038-2587	396640006	110029302C

124	Newington	06-1026214	1043209794	Hudson Home Health Care, Inc.	151 Rockwell Road	Newington	CT	06111-5535	396640001	004021234
126	Iowa City	62-1400785	1003213448	National Seating & Mobility, Inc.	2415 Heinz Rd, Ste 1	Iowa City	IA	52240-2660	570710115	1003213448
127	Des Moines	62-1400785	1407253560	National Seating & Mobility, Inc.	3936 NW Urbandale Dr.	Urbandale	IA	50322-7922	570710114	1407253560
129	Indy NW	62-1400785	1093112435	National Seating & Mobility, Inc.	7050 N. Guion Rd. Ste. A & B	Indianapolis	IN	46268-4812	0570710118	100194330 I
130	Redding	62-1400785	1215323266	National Seating & Mobility, Inc.	1240 Redwood Blvd	Redding	CA	96003-1964	570710117	1215323266
131	New York	55-0808048	1215933791	Home Medical Equipment, LLC.	1050 Stewart Ave. STE 120	Garden City	NY	11530-4888	4689850001	02386423
132	Fort Lauderdale	62-1400785	1225401284	National Seating & Mobility, Inc.	1406 SW 13th Court	Pompano Beach	FL	33069-4709	0570710124	018542500
133	Allentown	62-1400785	1760846836	National Seating & Mobility, Inc.	2030 Center Street Ste. 103	Northampton	PA	18067-1357	570710123	100730412 0020
134	Reading	62-1400785	1760842082	National Seating & Mobility, Inc.	3324 Plaza Drive	Reading	PA	19605-2418	570710122	100730412
135	Marquette	62-1400785	1922468321	National Seating & Mobility, Inc.	2612 US 41 West	Marquette	MI	49855-8879	0570710120	1922468321
136	La Crosse	62-1400785	1467812867	National Seating & Mobility, Inc.	1551 Miller Street, STE A & B	La Crosse	WI	54601-5219	0570710121	1467812867
138	Cartersville	62-1400785	1972950293	National Seating & Mobility, Inc.	15 Heatco Court SW STE A	Cartersville	GA	30120-1804	570710125	003189842A
139	Indianapolis Access	62-1400785	1093112435	National Seating & Mobility, Inc.	7050 N. Guion Rd. Ste. A & B	Indianapolis	IN	46268-4812	0570710118	N/A
140	Portland	62-1400785	1245786235	National Seating & Mobility, Inc.	8239 SW Cirrus Drive, STE 16G	Beaverton	OR	97008-5995	570710126	1245786235
141	Washington DC	62-1400785	1134672066	National Seating & Mobility, Inc.	7420 Fullerton Road Suite 100	Springfield	VA	22153-2836	570710127	1134672066
142	Raleigh	62-1400785	1982127429	National Seating & Mobility, Inc.	12362 Oak Avenue	Bailey	NC	27807-9331	570710136	1982127429
143	Tampa	62-1400785	1255881587	National Seating & Mobility, Inc.	7219 Bryan Dairy Rd	Largo	FL	33777-1505	0570710130	021022000
144	Los Angeles	62-1400785	1780135178	National Seating & Mobility, Inc.	1210 E. 223rd Street, Ste 322	Carson	CA	90745-4248	570710129	1780135178
145	Columbia	62-1400785	1669924551	National Seating & Mobility, Inc.	1401 St. Andrews Rd. Suite 120	Columbia	SC	29210-1333	570710132	DE3789
146	Augusta	62-1400785	1104378009	National Seating & Mobility, Inc.	1022 Walton Way, Ste D	Augusta	GA	30901-2861	0570710128	003189842A
148	Savannah	62-1400785	1659823557	National Seating & Mobility, Inc.	6409 Abercorn ST, STE B-1	Savannah	GA	31405-5796	0570710133	003198345A
149	Baltimore	62-1400785	1821531922	National Seating & Mobility, Inc.	7389 Washington Blvd. Suite 101	Elkridge	MD	21075-6348	0570710131	2002701 00
150	Cumberland	62-1400785	1881133569	National Seating & Mobility, Inc.	1313 National Highway Suite 13	La Vale	MD	21502-7616	0570710134	1400304 00
151	Jacksonville	62-1400785	1700311065	National Seating & Mobility, Inc.	11651 Central Parkway, STE 121	Jacksonville	FL	32224-2709	0570710145	024650400
152	Seattle	27-0793241	1568695476	Dependable Medical Equipment, Inc	6601 220th ST SW STE 6	Mountlake Terrace	WA	98043-2166	6443570001	9063108
155	Lansing	62-1400785	1912423849	National Seating & Mobility, Inc.	419 Lentz Court	Lansing	MI	48917-3702	0570710153	1912423849
157	Lincoln	62-1400785	1851819338	National Seating & Mobility, Inc.	3900 S 6th St Ste 10	Lincoln	NE	68502-5354	0570710139	10025202502

158	Harrisburg	62-1400785	1649798794	National Seating & Mobility, Inc.	6360 Flank Dr., STE 1500	Harrisburg	PA	17112-2279	0570710140	100730412 0024
159	Abilene	62-1400785	1295245223	National Seating & Mobility, Inc.	3374 S. Treadaway BLVD	Abilene	TX	79602-6736	570710137	383008501
160	Midland	62-1400785	1396255329	National Seating & Mobility, Inc.	1020 Andrews HWY, STE E	Midland	TX	79701-3811	570710138	388958601
161	St. Louis	62-1400785	1053823856	National Seating & Mobility, Inc.	502 Earth City Plaza Ste 200	Earth City	MO	63045-1315	0570710141	Rejected - in the process of resubmitting
162	Bangor	06-1026214	1235643289	Hudson Home Health Care, Inc.	625 Broadway Unit C	Bangor	ME	04401-3375	39664011	1181340003
164	Anchorage	62-1400785	1790289957	National Seating & Mobility, Inc.	2000 W. International Airport Rd Suite D3 & D4	Anchorage	AK	99518-1106	570710142	1686421
165	Olympia	62-1400785	1912494626	National Seating & Mobility, Inc.	5709 Lacey BLVD SE Ste 200	Lacey	WA	98503-2495	570710143	2106060
166	Flint Michigan	62-1400785	1881198430	National Seating & Mobility, Inc.	G1101 N Ballenger Hwy STE B	Flint	MI	48504-4433	0570710149	1881198430
167	Temperance	62-1400785	1013405984	National Seating & Mobility, Inc.	3200 W. Temperance Rd STE B	Temperance	MI	48182-2415	0570710151	1013405984
168	Chattanooga	62-1400785	1407344740	National Seating & Mobility, Inc.	2180 Stein Drive, Ste 106	Chattanooga	TN	37421-7247	0570710146	Q041254
169	Knoxville	62-1400785	1952899205	National Seating & Mobility, Inc.	115 Hayfield Road, Ste A	Knoxville	TN	37922-2361	0570710144	Q038508
170	Kingsport	62-1400785	1124516471	National Seating & Mobility, Inc.	3708 E Stone Drive	Kingsport	TN	37660-7112	0570710150	Q049306
174	South Burlington	62-1400785	1053898585	National Seating & Mobility, Inc.	1225 Airport Parkway Ste B	South Burlington	VT	05403-5805	570710148	Pending
175	Oklahoma City North	62-1400785	1720565898	National Seating & Mobility, Inc.	3401 N. May Ave., STE 3401 A & C	Oklahoma City	OK	73112-6904	PENDING	PENDING
177	Sayre	62-1400785	1669959904	National Seating & Mobility, Inc.	117 N Keystone Ave	Sayre	PA	18840-1403	570710147	1007304120025
178	Santa Barbara	62-1400785	1235612607	National Seating & Mobility, Inc.	310 Pine Ave. STE A	Goleta	CA	93117-3735	570710152	Pending
180	Albuquerque	62-1400785	1093285330	National Seating & Mobility, Inc.	7216 Washington NE, STE F	Albuquerque	NM	87109-4514	0570710154	PENDING
181	The Bronx	06-1026214	1093280455	Hudson Home Health Care, Inc.	1513 Olmstead Ave	Bronx	NY	10462-4254	570710147	Pending
186	Ft Worth	62-1400785	1295299899	National Seating & Mobility, Inc.	5470 E Loop 820 Ste 110	Fort Worth	TX	76119-6515	PENDING	Not Submitted
188	Martinez	62-1400785	1447718994	National Seating & Mobility, Inc.	825 Arnold Drive Suite 112	Martinez	CA	94553-6837	0570710156	Pending
190	North Charlotte	62-1400785	1447719810	National Seating & Mobility, Inc.	8421 Old Statesville Road, Suite 18	Charlotte	NC	28269-1838	PENDING	PENDING

4Z

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☒ Ownership Change

(Please provide current license number if making changes: MP or MW MP01605)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☒ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Onduo, LLC

Physical Address: 55 Chapel Street, Suite 300 Newton, MA 02458

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

Mailing Address: 55 Chapel Street, Suite 300

City: Newton State: MA Zip Code: 02458

Telephone: 833-446-6386 Fax: _____

E-mail: Legal@onduo.com Website: www.onduo.com

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 5PM

Fri: 9AM to 5PM Sat: ____ to ____ Sun: ____ to ____ Holidays: ____ to ____

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Patrick Cunningham, VP of Commercial Development Administrator unchanged from original application

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: Continuous Glucose Monitor (CGM) Devices

**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 OUT-OF-STATE 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:

Onduo, LLC does not serve Medicare or Medicaid populations, and does not maintain provider numbers to bill for services

_____ _____ _____

_____ _____ _____

_____ _____ _____

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 ☒

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 ☒

Are any of the owners health professionals? If yes, please 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.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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

Patrick Cunningham, VP of Commercial Development
Print Name of Authorized Person

11/19/2019
Date

Board Use Only	Received: _____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: _____

Corporation Name: Onduo, LLC

Mailing Address: 55 Chapel Street, Suite 300

City: Newton State: MA Zip: 02458

Telephone: 833-446-6386 Fax: 833-446-6386

Contact Person: Patrick Cunningham

For any corporation non publicly traded, disclose the following:

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

a) Verily Life Sciences, LLC 269 East Grand Ave. South San Francisco, CA 94080
Name Address

b) Aventis, Inc 55 Corporate Drive Bridgewater, NJ 08807
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. 1,199,604,687

3) What was the price paid per share? $1.43

4) What date did the corporation actually receive the cash assets? November 11, 2019

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

Include 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.

Onduo, LLC
55 Chapel Street, Suite 300
Newton, MA, 02458

Onduo, LLC - Ownership Structure

Entity Name: Onduo, LLC

Entity Type: Limited Liability Company

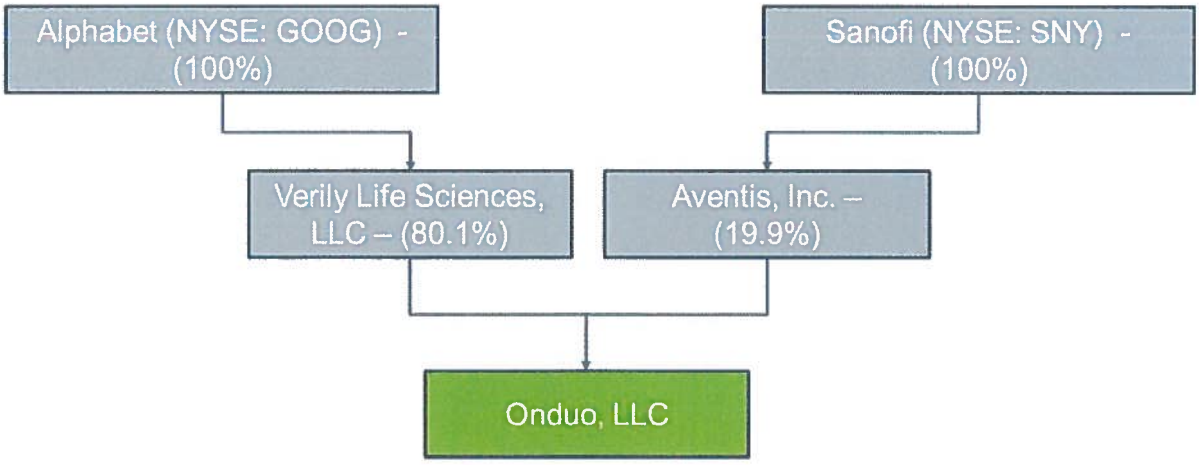
State of Formation: Delaware

Date of Formation: February 23rd, 2016

Ownership Structure – New Structure as of 11/14/2019

Stockholder	Ownership	Location
Verily Life Sciences, LLC	80.1%	269 East Grand Avenue South San Francisco, CA 94080
Aventis, Inc.	19.9%	55 Corporate Drive Bridgewater, NJ 08807

Ownership Structure Second Level



Shares were formerly held 50% by Verily Life Sciences, LLC and 50% by Aventis, Inc.

Onduo, LLC
55 Chapel Street, Suite 10
Newton, MA, 02458

Onduo, LLC - Officer Schedule

Name	Title	Office Location
Dr. Joshua Riff	Chief Executive Officer	55 Chapel Street Newton, MA 02458
Patrick Cunningham	VP of Commercial Development	55 Chapel Street Newton, MA 02458
Dr. Ronald F. Dixon	Head of Clinical Affairs	55 Chapel Street Newton, MA 02458
Gino Korolev	VP of Product	55 Chapel Street Newton, MA 02458
Michael Lawrence	Head of Strategy	55 Chapel Street Newton, MA 02458
Daniel Moloney	Head of Data Analytics	55 Chapel Street Newton, MA 02458
Lori Scanlon	VP of Marketing	55 Chapel Street Newton, MA 02458
Heather Zeitz	Head of Programs & User Experience	55 Chapel Street Newton, MA 02458

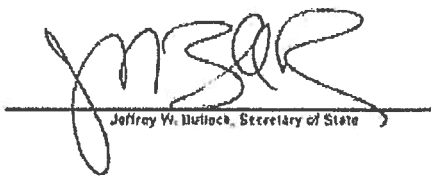
Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "ONDUO LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE NINETEENTH DAY OF NOVEMBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "ONDUO LLC" WAS FORMED ON THE TWENTY-THIRD DAY OF FEBRUARY, A.D. 2016.





5971749 8300

SR# 20198166050

Authentication: 204037041

Date: 11-19-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/19/2019

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 Marsh & McLennan Agency LLC 100 Front St, Ste 800 Worcester MA 01608	**CONTACT NAME:** **PHONE (A/C, No, Ext):** 888-850-9400 **FAX (A/C, No):** 866-795-8016 **E-MAIL ADDRESS:** MMA.NewEngland.CLines@marshmc.com
INSURED ONDUO Onduo, LLC 55 Chapel Street, Suite 300 Newton MA 02458	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Great Northern Insurance Company — 20303 **INSURER B :** Federal Insurance Company — 21784 **INSURER C :** Lloyd's Syndicate 2623/623 — 55555 **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** 88983340 **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:			36039618	1/1/2019	1/1/2020	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 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ $
B	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY X HIRED AUTOS ONLY SCHEDULED AUTOS X NON-OWNED AUTOS ONLY			1973601717	1/1/2019	1/1/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			78180861	1/1/2019	1/1/2020	EACH OCCURRENCE AGGREGATE 	$ 5,000,000 $ 5,000,000 $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (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	 $ $ $
C	Tech Products Liability Professional Liability			W20ADD190201	1/1/2019	1/1/2020	Each Claim/Agg/Ded. Each Claim/Agg/Ded. Policy Aggregate	$1M / $3M / $10K $1M / $3M / $10K $3,000,000

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

CERTIFICATE HOLDER

Onduo, LLC
Evidence of Coverage

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

© 1988-2015 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Office of Public Protection
239 Causeway Street, Suite 500, Boston, MA 02114

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-973-0865
TTY : 617-973-0988
Fax : 617-973-0985
www.mass.gov/dph/boards

Onduo, LLC
Attn: Patrick Cunningham
55 Chapel Street, Suite 10
Newton, MA 02458

To whom it may concern:

I am writing in response to your inquiry to the Massachusetts Board of Registration in Pharmacy regarding state licensing requirements for medical devices.

In Massachusetts, all medical devices fall under the jurisdiction of the Massachusetts Drug Control Program (DCP) of the Department of Public Health (DPH).

A controlled substance registration would be required if a company were to manufacture, distribute, or dispense a medical device containing a prescription pharmaceutical.

If the device does not contain medication, registration is not required.

Also, if the medical device is not manufactured, stored, dispensed, or distributed from within the Commonwealth, then a controlled substance registration would not be required.

Regards,

David Sencabaugh

Joshua Riff
Onduo LLC
55 Chapel Street
Newton, MA 02458

October 25, 2018

RE: Accreditation Award

Dear Joshua Riff,

The Healthcare Quality Association on Accreditation is pleased to inform you that Onduo LLC meets the DME accreditation requirements under section 1834(a)(20) of the Social Security Act (SSA) and the federal regulations at 42 CFR 424.58. HQAA has based this finding on a review of your application and an onsite survey conducted October 24, 2018.

This three-year accreditation award applies to the following Onduo LLC location through October 24, 2021:

55 Chapel Street
Newton, MA 02458
NPI # 1831620293

Please maintain a copy of your current equipment list with this letter. We look forward to working with you as you serve your customers throughout your service area. If you have any questions, please contact us.

Sincerely,

Rhonda Pearce
Executive Director

Award of Accreditation

For DMEPOS Products & Services

Awarded to

Onduo LLC

d/b/a: Onduo LLC

Newton, MA

HQAA ID # 6V5XDYTBM

On this day of

October 24, 2018

For the dedicated commitment of demonstrating high standards of quality in business and patient care.

HQAA

HEALTHCARE QUALITY ASSOCIATION ON ACCREDITATION

Rhonda Pearce

President, CEO Signature

or Executive Director Signature

This accreditation award is in effect for three years from the above date.

HQAA ACCREDITED

4AA

148

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG 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 MDEG ☐ Ownership 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 1,2,3,5 ☑ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

FACILITY INFORMATION

Facility Name: Golden Max LLC (dba Optimal)

Physical Address: 12701 Directors Drive, Stafford, Texas 77477

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

Mailing Address: 12701 Directors Drive

City: Stafford State: Zip Code: TX 77477 Telephone: 832-886-5300

Fax: 832-886-5311

E-mail: customercare@optimalmax.com Website: http://www.optimalmax.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 6 am to 5pm Tue: 6am to 5pm Wed: 6am to 5pm Thu: 6am to 5pm Fri: 6am to 5pm Sat: N/A to Sun: N/A to Holidays: N/A to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Christopher Johnson

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: AEDs

**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: N/A Telephone: _____

APPLICATION FOR OUT-OF-STATE 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:

N/A _____ _____ _____

_____ _____ _____

_____ _____ _____

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 ☐

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 ☐

Are any of the owners health professionals? If yes, please list name.

- Practitioner — Name: N/A
- Advanced Practitioner of Nursing — Name: N/A
- Physician's Assistant — Name: N/A
- Physical Therapist — Name: N/A
- Occupational Therapist — Name: N/A
- Registered Nurse — Name: N/A
- Respiratory Therapist — Name: N/A

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

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☑

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 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 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.

Victor Bacchioni

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

Victor Bacchioni (CFO)

Print Name of Authorized Person

10/14/2019

Date

Board Use Only	Received:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

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

Owner's Name: Eric Jin-Shin Liu

List all previous names: Jin-Shin Liu

Social Security Number: _____

Date of Birth: _____

Place of Birth: City: _____ State: _____ Country: Taiwan

Citizenship: USA YES other _____

If applicable, list Naturalization Number: _____ Passport Number: (_____

Current residence address: Bradford Road City: Manhasset

State: NY Zip Code: 11030 Telephone Number: _____ Fax Number: _____

Previous address (last 5 years):

Address: Same as above City: _____ State: Zip Code: _____

Address: _____ City: _____ State: Zip Code: _____

Address: _____ City: _____ State: Zip Code: _____

Address: _____ City: _____ State: Zip Code: _____

Business Name: Golden Max LLC (dba Optimal)

Current Business Address: 12701 Directors Drive

City: Stafford State: Texas Zip Code: 77477

Telephone Number: 832-886-5300 Fax Number: 832-886-5311

Previous Employment (last 5 years):

Name: Golden Max LLC (Owner) Address: 12701 Directors Drive

City: Stafford State: Texas Zip Code: 77477

Name: GMAX Industries, Inc.(Owner) Address: 2150 Joshua's Path, Suite 205

City: Hauppauge State: NY Zip Code: 11788

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2019

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 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: Nancy Gannon
Foa & Son Corporation 68 South Service Road Suite 210 Melville NY 11747-2357	PHONE (A/C, No, Ext): (516)228-1234 FAX (A/C, No): (516)228-1235 E-MAIL ADDRESS: Nancy.Gannon@FoaSon.com

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Golden Max LLC dba Optimal 12701 Directors Drive Stafford TX 77477	INSURER A: Great Northern Ins. Company	20303
	INSURER B: Federal Insurance Co.	20281
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** CL191254716 **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:			3602-87-51	1/1/2019	1/1/2020	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 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ *See below
B	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			7359-14-38	1/1/2019	1/1/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 0			7989-60-69	1/1/2019	1/1/2020	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 10,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N N/A If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
B	*Products/Completed Ops Claims Made / $50,000 Ded			9949-68-98 Retro Date 11/13/2015	1/1/2019	1/1/2020	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 10,000,000

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

CERTIFICATE HOLDER

EVIDENCE OF COVERAGE

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

Justin Foa/DL

Justin Foa ENCLOSURE REG#104

© 1988-2014 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

4BB

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521 (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**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
(Please provide current license number if making changes: MP or MW_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5
☐ 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.

FACILITY INFORMATION

Facility Name: Southeast Medical Services Inc

Physical Address: 280 Wekiva Springs Road Suite 2000
(This must be a business address, we cannot issue a license to a home address)

Mailing Address: Same

City: Longwood State: FL Zip Code: 32779

Telephone: 800-404-9761 Fax: 888-404-9762

E-mail: scott@smsnational.net Website: https://smsnational.net

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:30 to 7:00 Tue: 8:30 to 7:00 Wed: 8:30 to 7:00 Thu: 8:30 to 7:00 Fri: 8:30 to 7:00 Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Scott Higley VP of Operations

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: _____

**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 OUT-OF-STATE 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:

NA		

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 ☒

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 ☒

Are any of the owners health professionals? If yes, please list name.

- Practitioner — Name: NA
- 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.

1) Has the corporation, any owner(s), shareholder(s) or partners 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 ☒

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

This page must be submitted for all types of ownership.

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 ☒

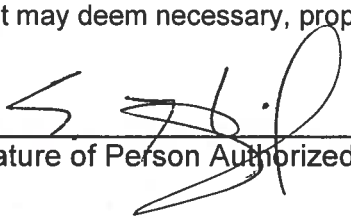
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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 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 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

Scott Higley
Print Name of Authorized Person

12/4/2019
Date

Board Use Only	Received:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

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

Owner's Name: Eileen Salem

List all previous names: Eileen Mastrapa Salem

Social Security Number: _____

Date of Birth: _____

Place of Birth: City: Santa Clara State: _____ Country: Cuba

Citizenship: USA Yes other _____

If applicable, list Naturalization Number: _____ Passport Number: _____

Current residence address: _ ! Magnolia Lake Court City: Longwood

State: FL Zip Code: 32779 Telephone Number: _ _____ Fax Number: 888-404-9762

Previous address (last 5 years):
Address: 920 Fairmeadows Ct City: Lake Mary State: FL Zip Code: 32746

Address: _____ City: _____ State: Zip Code: _____

Address: _____ City: _____ State: Zip Code: _____

Address: _____ City: _____ State: Zip Code: _____

Business Name: Southeast Medical Services Inc. dba SMS National

Current Business Address: 280 Wekiva Springs Road, Ste 2000

City: Longwood State: FL Zip Code: 32779

Telephone Number: 800-404-9761 Fax Number: 888-404-9762

Previous Employment (last 5 years):

Name: NA Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/7/2019

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 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: Commercial Service	
Alliance and Associates Financial Services II, LLC 1091 Oakleaf Plantation Pkwy Orange Park FL 32065	PHONE (A/C, No, Ext): 855-792-2804	FAX (A/C, No): 904-930-4672
	E-MAIL ADDRESS: certificates@alliance321.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : United Specialty Ins Co	12537
INSURED Southeast Medical Services 280 Wekiva Springs Rd. Suite 2000 Longwood FL 32779	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 [X] CLAIMS-MADE [ ] OCCUR [X] Professional Liability GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:			VGM10812000718-5	01/16/2019	01/16/2020	EACH OCCURRENCE	$ 3,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 5,000,000
							PRODUCTS - COMP/OP AGG	$ 5,000,000
								$
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [ ] HIRED AUTOS [ ] NON-OWNED AUTOS						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 Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						[ ] PER STATUTE [ ] OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Sexual or Physical Abuse			VGM10812000718-5	01/16/2019	01/16/2020	Aggregate $300,000 Each claim $100,000	

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

CERTIFICATE HOLDER

For Insurance Purposes

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

Melody McCoy

© 1988-2014 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

4CC

NEVADA STATE BOARD OF PHARMACY

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 MP00731)

☐ 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: National Seating & Mobility, Inc.

Physical Address: 7666 Commercial Way Ste H Henderson NV 89011-6630

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

Mailing Address: 5959 Shallowford Rd Ste 443

City: Chattanooga State: TN Zip Code: 37421-2245

Telephone: (Phys) 702-565-5570 (Mail) 423-756-2268 Fax: (Phys) 800-264-9032 (Mail) 423-362-5413

E-mail: (Phys) lasvegas@nsm-seating.com (Mail) NSMWest@nsm=seating.com Website: www.nsm-seating.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 8am to 5pm Sat: Closed to Sun: Closed to Holidays: Closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: N/A

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: DME/CRT

**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: N/A 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:

See Attached	See Attached	See Attached

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.

N/A

- ☐ 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.

Within the last five (5) years:

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

Jeffrey Matukewicz
Print Name of Authorized Person

11/25/2019
Date

Board Use Only	Received: _____	Amount: 600.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: TN

Parent Company if any: _____

Corporation Name: National Seating & Mobility, Inc.

Mailing Address: 5959 Shallowford Rd Ste 443

City: Chattanooga State: TN Zip: 37421-2245

Telephone: 423-756-2268 Fax: 423-362-5413

Contact Person: Stephanie Baggett

For any corporation non publicly traded, disclose the following:

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

a) N/A
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

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

3) What was the price paid per share? _____

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

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

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

1/31/2017

DATE (MM/DD/YYYY) 10/27/2016

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
Lockton Companies
8110 E. Union Avenue
Suite 700
Denver CO 80237
(303) 414-6000

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Fire and Marine Insurance Co	20079
INSURER B : New Hampshire Indemnity Company, Inc.	23833
INSURER C : Granite State Insurance Company	23809
INSURER D : New Hampshire Insurance Company	23841
INSURER E : Insurance Company of the State of PA	19429
INSURER F :	

INSURED
1418818
National Seating & Mobility
5959 Shallowford Road, Suite 443
Chattanooga, TN 37421

COVERAGES **CERTIFICATE NUMBER:** 14351439 **REVISION NUMBER:** XXXXXXX

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	N	N	42-GLO-100396-02	10/31/2015	1/31/2017	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X Prof Liability						MED EXP (Any one person)	$ XXXXXXX
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	$ 1,000,000
	POLICY [ ] PRO-JECT [ ] LOC						GENERAL AGGREGATE	$ 2,000,000
	OTHER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
B	AUTOMOBILE LIABILITY	N	N	2305047 (AOS)	10/31/2016	1/31/2017	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
C	X ANY AUTO			2305050 (MA)	10/31/2016	1/31/2017	BODILY INJURY (Per person)	$ XXXXXXX
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$ XXXXXXX
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$ XXXXXXX
								$ XXXXXXX
A	X UMBRELLA LIAB [X] OCCUR	N	N	42-UMO-100397-02	10/31/2015	1/31/2017	EACH OCCURRENCE	$ 5,000,000
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$ 5,000,000
	DED [ ] RETENTION $							$ XXXXXXX
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N		N	12852207(AOS)	10/31/2016	1/31/2017	X PER STATUTE [ ] OTH-ER	
E	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] N/A (Mandatory in NH)			12852208 (CA)	10/31/2016	1/31/2017	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Location #88 Vegas – 7665 Commercial Way, Ste H, Henderson NV 89011

OCT 31 2016

CERTIFICATE HOLDER

14351439

Nevada State Board of Pharmacy
431 W Plumb Ln
Reno NV 89509

CANCELLATION See Attachments

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

Charles M. McDaniel

ACORD 25 (2016/03)

©1988-2015 ACORD CORPORATION. All rights reserved
The ACORD name and logo are registered marks of ACORD

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

TRICIA H PAGE
STE #443
5959 SHALLOWFORD RD
CHATTANOOGA, TN 37421

December 19, 2012

Request Type: Certificate of Existence/Authorization
Request #: 0085514

Issuance Date: 12/19/2012
Copies Requested: 1

Document Receipt

Receipt # : 862666 — Filing Fee: $22.25

Payment-Credit Card - TennesseeAnytime Online Payment #: 148161510 — $22.25

Regarding: **NATIONAL SEATING & MOBILITY, INC.**
Filing Type: Corporation For-Profit - Domestic
Formation/Qualification Date: 05/10/1989
Status: Active
Duration Term: Perpetual
Business County: HAMILTON COUNTY

Control # : 215678
Date Formed: 05/10/1989
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

NATIONAL SEATING & MOBILITY, INC.

* is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent corporation annual report required with this office;

* has appointed a registered agent and registered office in this State;

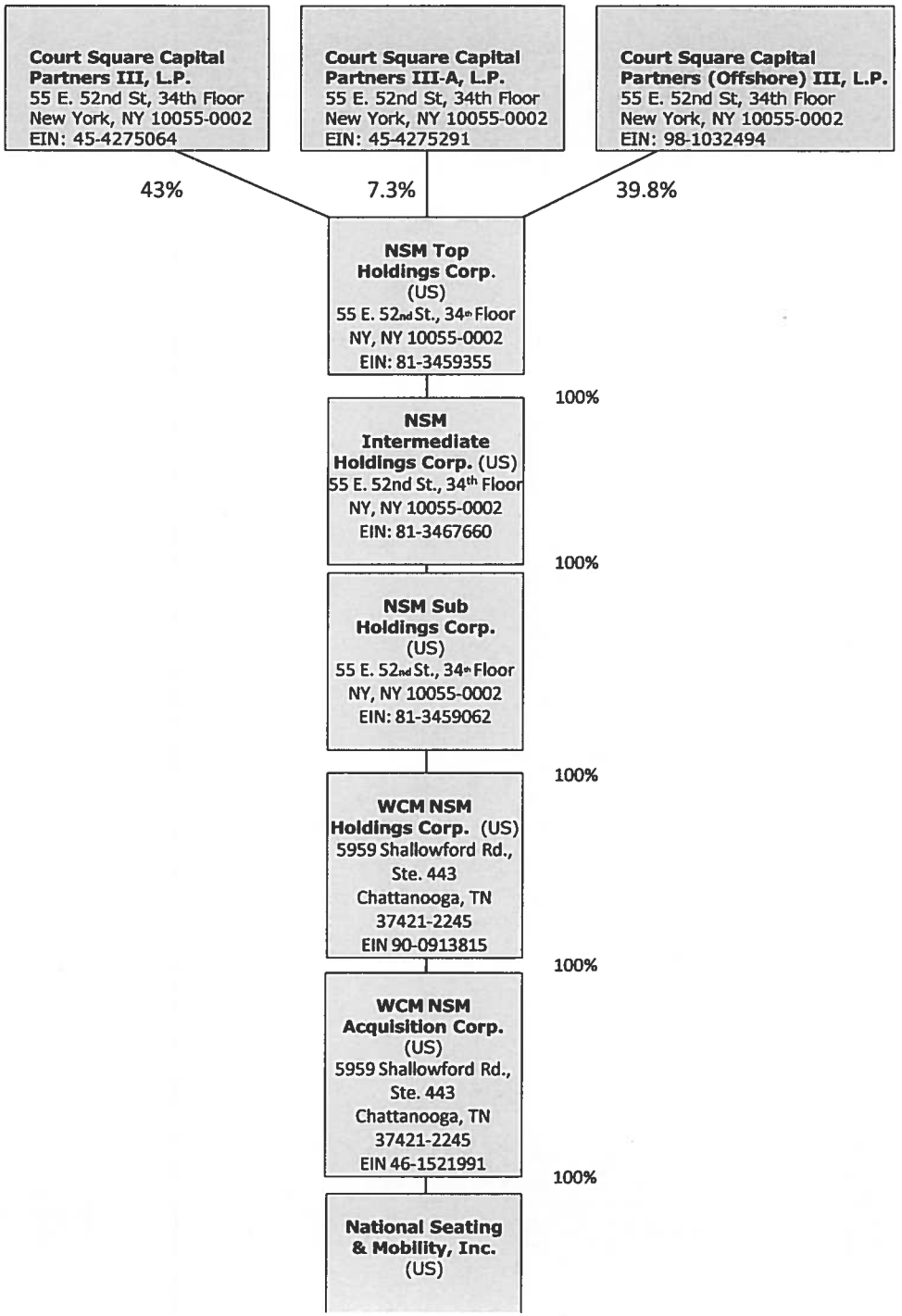
* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

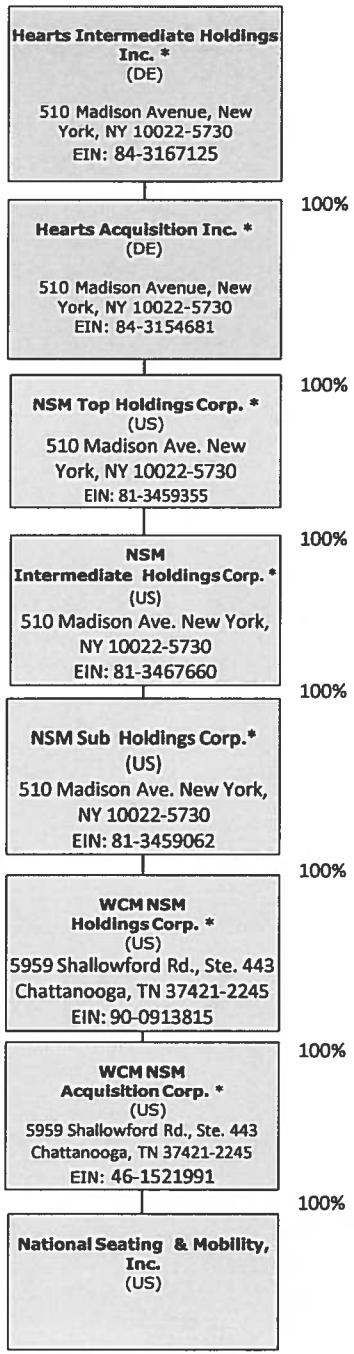
Processed By: Cert Web User

Verification #: 002228217

Pre-Close Legal Entity Structure



Post-Close Legal Entity Structure



* Entity may be converted to LLC following the close but will maintain the same FEIN and business address

Branch #	Branch Name	TaxId	NPI	ProviderName	Branch Address	Branch City	Branch State	Zip Code	Medicare ID	Medicaid ID
02	Birmingham	62-1400785	1548235260	National Seating & Mobility, Inc.	2521 MeadowView Lane Suite D	Pelham	AL	35124-4343	0570710003	000057245
03	Miami	62-1400785	1174596019	National Seating & Mobility, Inc.	1335 NW 98th Court Unit 1	Doral	FL	33172-2777	0570710004	029905700
04	Houston	62-1400785	1477526333	National Seating & Mobility, Inc.	9494 Kirby Drive	Houston	TX	77054-3905	570710006	016241404
05	Atlanta	62-1400785	1770556623	National Seating & Mobility, Inc.	3417 Oakcliff Road, STE 106	Doraville	GA	30340-3004	0570710002	000521595A
07	Arlington	62-1400785	1891768735	National Seating & Mobility, Inc.	2300 Valley View Lane, STE 205	Farmers Branch	TX	75234-5737	570710005	009921006
08	Chatsworth	62-1400785	1053384990	National Seating & Mobility, Inc.	21807 Plummer Street	Chatsworth	CA	91311-4110	570710008	1053384990
11	Anaheim	62-1400785	1235102179	National Seating & Mobility, Inc.	1125 East Stanford Court	Anaheim	CA	92805-6822	570710011	1235102179
13	Mobile	62-1400785	1558334474	National Seating & Mobility, Inc.	854 Lakeside Drive Suite B	Mobile	AL	36606-2034	0570710075	009507090
16	Chicago	62-1400785	1003889684	National Seating & Mobility, Inc.	5444 East Ave Unit A	Countryside	IL	60525-3671	0570710020	621400785001
18	Stockton	62-1400785	1194799635	National Seating & Mobility, Inc.	4515 South B Street	Stockton	CA	95206-3956	570710019	1194799635
19	San Jose	62-1400785	1376516922	National Seating & Mobility, Inc.	1190 Dell Ave., Unit L	Campbell	CA	95008-6614	570710016	1376516922
20	Evansville	62-1400785	1265405104	National Seating & Mobility, Inc.	2626 Kotter Ave., STE C	Evansville	IN	47715-8530	0570710018	100194330C
22	Hayward	62-1400785	10533384982	National Seating & Mobility, Inc.	2462 Tripaldi Way	Hayward	CA	94545-5017	570710026	1053384982
23	Milwaukee	62-1400785	1972576528	National Seating & Mobility, Inc.	12020 W. Feerick St Ste A	Wauwatosa	WI	53222-2120	0570710024	1972576528
24	Madison	62-1400785	1013980945	National Seating & Mobility, Inc.	726 Walsh Rd	Madison	WI	53714-1370	0570710023	1013980945
25	San Diego	62-1400785	1356314900	National Seating & Mobility, Inc.	7945 Dunbrook Rd. Suite F&G	San Diego	CA	92126-6323	570710026	1356314900
26	Bakersfield	62-1400785	1790758340	National Seating & Mobility, Inc.	4705 New Horizon Blvd., Ste. 2	Bakersfield	CA	93313-2369	570710027	1790758340
28	Toledo	62-1400785	1881667434	National Seating & Mobility, Inc.	6501 Angola Road Unit P	Holland	OH	43528-9651	0570710029	2058464
29	Greenville	62-1400785	1427021369	National Seating & Mobility, Inc.	153 Grace Dr. Unit A	Easley	SC	29640-9088	570710032	DE1262
30	Montgomery	62-1400785	1508839432	National Seating & Mobility, Inc.	1406 I-85 Parkway	Montgomery	AL	36106-2813	0570710031	009814350
33	Troy	62-1400785	1891768719	National Seating & Mobility, Inc.	1967 Woodslee Drive	Troy	MI	48083-2236	0570710035	1891768719
34	Lexington	62-1400785	1205809126	National Seating & Mobility, Inc.	2025 Leestown Rd. Unit L	Lexington	KY	40511-1000	570710036	90001470
36	Fresno	62-1400785	1538132444	National Seating & Mobility, Inc.	4980 E. University Ave., Unit 114	Fresno	CA	93727-1659	570710042	1538132444
38	Sacramento	62-1400785	1225001894	National Seating & Mobility, Inc.	3651 Buisness Dr. STE 120	Sacramento	CA	95820-2176	570710043	1225001894
39	Santa Rosa	62-1400785	1982677530	National Seating & Mobility, Inc.	3535 Industrial Drive Suite B1	Santa Rosa	CA	95403-2039	570710040	1982677530
40	Fairfield	62-1400785	1265405815	National Seating & Mobility, Inc.	2850 Cordelia Rd. Ste. 150	Fairfield	CA	94534-1655	570710044	1265405815
45	Philadelphia	62-1400785	1326011263	National Seating & Mobility, Inc.	1957 Pioneer Road, BLDG C	Huntingdon Valley	PA	19006-2503	570710045	1007304120017

47	Natick	62-1400785	1679546519	National Seating & Mobility, Inc.	8 Erie Drive Unit A	Natick	MA	01760-1313	570710046	110028194a
48	Memphis	62-1400785	1932172871	National Seating & Mobility, Inc.	3930 South Perkins Road	Memphis	TN	38118-7029	570710053	1454087
49	Little Rock	62-1400785	1417920067	National Seating & Mobility, Inc.	7123 Interstate 30 Suite 13	Little Rock	AR	72209-3165	0570710047	140980716
50	Fort Smith	62-1400785	1043283963	National Seating & Mobility, Inc.	6901 Dallas Street Ste. A	Fort Smith	AR	72903-5037	0570710048	1043283963
52	Champaign	62-1400785	1467425017	National Seating & Mobility, Inc.	3808 W. Springfield Ave. Suite B	Champaign	IL	61822-8806	0570710054	621400785-006
53	Peoria	62-1400785	1932172848	National Seating & Mobility, Inc.	4209 Pfieffer Rd	Bartonville	IL	61607-2812	0570710055	621400785-005
54	Charleston, WV	62-1400785	1124091038	National Seating & Mobility, Inc.	200 Roxalana Business Park	Dunbar	WV	25064-2727	570710056	WV - 6203054000 KY - 7100275600 KY - 7100298740 OH - 0087013
57	Buffalo	62-1400785	1003889940	National Seating & Mobility, Inc.	19B Ransier Drive	West Seneca	NY	14224-2259	570710059	02527228
58	Wichita	62-1400785	1205809860	National Seating & Mobility, Inc.	1635 East 37th Street North Ste. 5	Wichita	KS	67219-3557	570710061	200253730A
59	Connecticut	62-1400785	1659344505	National Seating & Mobility, Inc.	11 Freedom Way A3-A6	Niantic	CT	06357-1041	570710060	004240339
60	Honolulu	62-1400785	1184699209	National Seating & Mobility, Inc.	96-1173 Waihona Street Ste A3	Pearl City	HI	96782-1931	570710062	55561701
61	Fort Wayne	62-1400785	1497728331	National Seating & Mobility, Inc.	3927 Kraft Pkwy Ste A	Ft. Wayne	IN	46825-4444	0570710021	100194330D
65	Chicopee	62-1400785	1841263621	National Seating & Mobility, Inc.	150 Padgette St. Unit F	Chicopee	MA	01022-1333	570710066	110028194B
68	Nashville	62-1400785	1598812232	National Seating & Mobility, Inc.	1610 Elm Hill Pike, Suite A	Nashville	TN	37210-3625	570710070	1455201
70	Redlands	62-1400785	1558428979	National Seating & Mobility, Inc.	350 Alabama St. Suites C,D & E	Redlands	CA	92373-8098	570710073	1558428979
71	Phoenix	62-1400785	1740347129	National Seating & Mobility, Inc.	8550 N. 91st Ave. Suite 79	Peoria	AZ	85345-8368	570710069	832341
72	San Antonio	62-1400785	1518174242	National Seating & Mobility, Inc.	8666 Huebner RD STE 100	San Antonio	TX	78240-1844	570710072	192883005
75	Orlando	62-1400785	1124218672	National Seating & Mobility, Inc.	715 West SR 434, STE Q	Longwood	FL	32750-4937	0570710076	003494000
76	Austin	62-1400785	1811183288	National Seating & Mobility, Inc.	2211 Denton Drive Suites GJ&L	Austin	TX	78758-4532	570710074	195210304
77	Salt Lake City	62-1400785	1710149299	National Seating & Mobility, Inc.	6553 South Cottonwood Street	Murray	UT	84107-6981	570710077	1710149299
79	Lafayette	62-1400785	1235381575	National Seating & Mobility, Inc.	207 Roto Park Drive	Broussard	LA	70518-4355	0570710080	1807981
80	New Orleans	62-1400785	1639322316	National Seating & Mobility, Inc.	5515 Pepsi St. Ste. A/B	Harrahan	LA	70123-3272	0570710085	1808016
82	Beaumont	62-1400785	1932347606	National Seating & Mobility, Inc.	10945 Eastex Freeway	Beaumont	TX	77708-0902	570710081	219171003
84	Louisville	62-1400785	1730327883	National Seating & Mobility, Inc.	11003 Bluegrass Parkway, Suite 460	Louisville	KY	40299-2392	570710078	7100101240
85	Ogden	62-1400785	1184863060	National Seating & Mobility, Inc.	1719 West 2800 South #102	Ogden	UT	84401-3263	570710084	1184863060
87	Columbus	62-1400785	1144458209	National Seating & Mobility, Inc.	306 E. 5th Ave	Columbus	OH	43201-2820	0570710087	3032800

88	Las Vegas	62-1400785	1154635878	National Seating & Mobility, Inc.	7665 Commercial Way, Suite H	Henderson	NV	89011-4084	570710089	1154635878
89	Minneapolis	62-1400785	1013224112	National Seating & Mobility, Inc.	1775 Old Highway 8 NW Ste 103	New Brighton	MN	55112-1891	0570710088	1013224112
91	McAllen	62-1400785	1225333099	National Seating & Mobility, Inc.	1201 W. Houston Avenue	McAllen	TX	78501-5012	570710090	285803705
92	Appleton	62-1400785	1508153370	National Seating & Mobility, Inc.	N922 Tower View Drive Unit N	Greenville	WI	54942-8097	0570710092	1508153370
94	Asheville	62-1400785	1649551474	National Seating & Mobility, Inc.	65 Shiloh Rd.	Asheville	NC	28803-2929	570710093	7705396
96	Billings	62-1400785	1740538883	National Seating & Mobility, Inc.	2747 Enterprise Ave.Ste. 4	Billings	MT	59102-7412	570710095	1740538883
97	Denver	62-1400785	1407198047	National Seating & Mobility, Inc.	12503 E. Euclid Dr. Ste. 60	Centennial	CO	80111-6400	570710096	08003717
98	Norfolk	62-1400785	1013351998	National Seating & Mobility, Inc.	3347 Enterprise Rd	Norfolk	VA	23502-1912	570710098	1013351998
99	Richmond	62-1400785	1710321690	National Seating & Mobility, Inc.	3941 Deep Rock Road	Richmond	VA	23233-1474	570710099	1710321690
101	Fisherville	62-1400785	1417391392	National Seating & Mobility, Inc.	88 Ivy Ridge Lane	Fishersville	VA	22939-3421	570710102	1417391392
103	Roanoke	62-1400785	1699114884	National Seating & Mobility, Inc.	5306 Peters Creek Rd. Ste. D.	Roanoke	VA	24019-3874	570710101	1699114884
105	Valdese	62-1400785	1821423229	National Seating & Mobility, Inc.	1031 Malcolm Blvd	Connelly Springs	NC	28612-7923	570710104	1821423229
106	Albany	62-1400785	1902232390	National Seating & Mobility, Inc.	12 Jupiter Lane, Unit 4	Albany	NY	12205-6918	570710103	03841967
107	Charlotte, NC	62-1400785	1740603075	National Seating & Mobility, Inc.	800 Central Ave.	Charlotte	NC	28204-2026	570710105	1740603075
108	Charleston, SC	62-1400785	1730504630	National Seating & Mobility, Inc.	2551 Oscar Johnson Drive. Suite C	North Charleston	SC	29405-6884	570710108	DE3533
109	New Jersey	62-1400785	1891113346	National Seating & Mobility, Inc.	5146 W. Hurley Pond Road	Wall Township	NJ	07727-1620	570710107	Out of Network
110	Jackson, MS	62-1400785	1295153674	National Seating & Mobility, Inc.	108 North Layfair Drive	Flowood	MS	39232-9782	0570710106	05826572
111	Providence, RI	62-1400785	1275947053	National Seating & Mobility, Inc.	11 Knight Street Unit F22-F23	Warwick	RI	02886-1397	570710109	1275947053
112	Oklahoma City	62-1400785	1982012951	National Seating & Mobility, Inc.	3500 S. Lakeside Drive	Oklahoma City	OK	73179-8400	570710111	100794550 D
113	Pittsburgh	62-1400785	1043619505	National Seating & Mobility, Inc.	730 Vista Park Ave	Pittsburgh	PA	15205-1214	570710110	1007304120019
115	Youngstown	62-1400785	1689078701	National Seating & Mobility, Inc.	1087 N. Meridian Rd.	Youngstown	OH	44509-1016	0570710113	0121640
116	Cleveland	62-1400785	1538556360	National Seating & Mobility, Inc.	6430 Eastland Rd	Brook Park	OH	44142-1340	0570710119	0152992
117	Hudson	06-1026214	1922285741	Hudson Home Health Care, Inc.	315 Derry Road, Unit 4 & 5	Hudson	NH	03051-3050	396640007	3076664
118	Fairfield	06-1026214	1730407768	Hudson Home Health Care, Inc.	1 Frassetto Way, Suite I	Lincoln Park	NJ	07035-2056	396640010	0195553
119	Plainview	06-1026214	1003052598	Hudson Home Health Care, Inc.	101 Fairchild Ave, Suite 2	Planview	NY	11803-1725	396640009	03161502
122	Woburn	06-1026214	1962470112	Hudson Home Health Care, Inc.	470 Wildwood Ave, Suite 4	Woburn	MA	01801-2082	396640005	1100293028
123	Franklin, MA	06-1026214	1750332797	Hudson Home Health Care, Inc.	101 Constitution Blvd Ste E	Franklin	MA	02038-2587	396640006	110029302C

124	Newington	06-1026214	1043209794	Hudson Home Health Care, Inc.	151 Rockwell Road	Newington	CT	06111-5535	396640001	004021234
126	Iowa City	62-1400785	1003213448	National Seating & Mobility, Inc.	2415 Heinz Rd, Ste 1	Iowa City	IA	52240-2660	570710115	1003213448
127	Des Moines	62-1400785	1407253560	National Seating & Mobility, Inc.	3936 NW Urbandale Dr.	Urbandale	IA	50322-7922	570710114	1407253560
129	Indy NW	62-1400785	1093112435	National Seating & Mobility, Inc.	7050 N. Guion Rd. Ste. A & B	Indianapolis	IN	46268-4812	0570710118	100194330 I
130	Redding	62-1400785	1215323266	National Seating & Mobility, Inc.	1240 Redwood Blvd	Redding	CA	96003-1964	570710117	1215323266
131	New York	55-0808048	1215933791	Home Medical Equipment, LLC.	1050 Stewart Ave. STE 120	Garden City	NY	11530-4888	4689850001	02386423
132	Fort Lauderdale	62-1400785	1225401284	National Seating & Mobility, Inc.	1406 SW 13th Court	Pompano Beach	FL	33069-4709	0570710124	018542500
133	Allentown	62-1400785	1760846836	National Seating & Mobility, Inc.	2030 Center Street Ste. 103	Northampton	PA	18067-1357	570710123	100730412 0020
134	Reading	62-1400785	1760842082	National Seating & Mobility, Inc.	3324 Plaza Drive	Reading	PA	19605-2418	570710122	100730412
135	Marquette	62-1400785	1922468321	National Seating & Mobility, Inc.	2612 US 41 West	Marquette	MI	49855-8879	0570710120	1922468321
136	La Crosse	62-1400785	1467812867	National Seating & Mobility, Inc.	1551 Miller Street, STE A & B	La Crosse	WI	54601-5219	0570710121	1467812867
138	Cartersville	62-1400785	1972950293	National Seating & Mobility, Inc.	15 Heatco Court SW STE A	Cartersville	GA	30120-1804	570710125	003189842A
139	Indianapolis Access	62-1400785	1093112435	National Seating & Mobility, Inc.	7050 N. Guion Rd. Ste. A & B	Indianapolis	IN	46268-4812	0570710118	N/A
140	Portland	62-1400785	1245786235	National Seating & Mobility, Inc.	8239 SW Cirrus Drive, STE 16G	Beaverton	OR	97008-5995	570710126	1245786235
141	Washington DC	62-1400785	1134672066	National Seating & Mobility, Inc.	7420 Fullerton Road Suite 100	Springfield	VA	22153-2836	570710127	1134672066
142	Raleigh	62-1400785	1982127429	National Seating & Mobility, Inc.	12362 Oak Avenue	Bailey	NC	27807-9331	570710136	1982127429
143	Tampa	62-1400785	1255881587	National Seating & Mobility, Inc.	7219 Bryan Dairy Rd	Largo	FL	33777-1505	0570710130	021022000
144	Los Angeles	62-1400785	1780135178	National Seating & Mobility, Inc.	1210 E. 223rd Street, Ste 322	Carson	CA	90745-4248	570710129	1780135178
145	Columbia	62-1400785	1669924551	National Seating & Mobility, Inc.	1401 St. Andrews Rd. Suite 120	Columbia	SC	29210-1333	570710132	DE3789
146	Augusta	62-1400785	1104378009	National Seating & Mobility, Inc.	1022 Walton Way, Ste D	Augusta	GA	30901-2861	0570710128	003189842A
148	Savannah	62-1400785	1659823557	National Seating & Mobility, Inc.	6409 Abercorn ST, STE B-1	Savannah	GA	31405-5796	0570710133	003198345A
149	Baltimore	62-1400785	1821531922	National Seating & Mobility, Inc.	7389 Washington Blvd. Suite 101	Elkridge	MD	21075-6348	0570710131	2002701 00
150	Cumberland	62-1400785	1881133569	National Seating & Mobility, Inc.	1313 National Highway Suite 13	La Vale	MD	21502-7616	0570710134	1400304 00
151	Jacksonville	62-1400785	1700311065	National Seating & Mobility, Inc.	11651 Central Parkway, STE 121	Jacksonville	FL	32224-2709	0570710145	024650400
152	Seattle	27-0793241	1568695476	Dependable Medical Equipment, Inc	6601 220th ST SW STE 6	Mountlake Terrace	WA	98043-2166	6443570001	9063108
155	Lansing	62-1400785	1912423849	National Seating & Mobility, Inc.	419 Lentz Court	Lansing	MI	48917-3702	0570710153	1912423849
157	Lincoln	62-1400785	1851819338	National Seating & Mobility, Inc.	3900 S 6th St Ste 10	Lincoln	NE	68502-5354	0570710139	10025202502

158	Harrisburg	62-1400785	1649798794	National Seating & Mobility, Inc.	6360 Flank Dr., STE 1500	Harrisburg	PA	17112-2279	0570710140	100730412 0024
159	Abilene	62-1400785	1295245223	National Seating & Mobility, Inc.	3374 S. Treadaway BLVD	Abilene	TX	79602-6736	570710137	383008501
160	Midland	62-1400785	1396255329	National Seating & Mobility, Inc.	1020 Andrews HWY, STE E	Midland	TX	79701-3811	570710138	388958601
161	St. Louis	62-1400785	1053823856	National Seating & Mobility, Inc.	502 Earth City Plaza Ste 200	Earth City	MO	63045-1315	0570710141	Rejected - in the process of resubmitting
162	Bangor	06-1026214	1235643289	Hudson Home Health Care, Inc.	625 Broadway Unit C	Bangor	ME	04401-3375	39664011	1181340003
164	Anchorage	62-1400785	1790289957	National Seating & Mobility, Inc.	2000 W. International Airport Rd Suite D3 & D4	Anchorage	AK	99518-1106	570710142	1686421
165	Olympia	62-1400785	1912494626	National Seating & Mobility, Inc.	5709 Lacey BLVD SE Ste 200	Lacey	WA	98503-2495	570710143	2106060
166	Flint Michigan	62-1400785	1881198430	National Seating & Mobility, Inc.	G1101 N Ballenger Hwy STE B	Flint	MI	48504-4433	0570710149	1881198430
167	Temperance	62-1400785	1013405984	National Seating & Mobility, Inc.	3200 W. Temperance Rd STE B	Temperance	MI	48182-2415	0570710151	1013405984
168	Chattanooga	62-1400785	1407344740	National Seating & Mobility, Inc.	2180 Stein Drive, Ste 106	Chattanooga	TN	37421-7247	0570710146	Q041254
169	Knoxville	62-1400785	1952899205	National Seating & Mobility, Inc.	115 Hayfield Road, Ste A	Knoxville	TN	37922-2361	0570710144	Q038508
170	Kingsport	62-1400785	1124516471	National Seating & Mobility, Inc.	3708 E Stone Drive	Kingsport	TN	37660-7112	0570710150	Q049306
174	South Burlington	62-1400785	1053898585	National Seating & Mobility, Inc.	1225 Airport Parkway Ste B	South Burlington	VT	05403-5805	570710148	Pending
175	Oklahoma City North	62-1400785	1720565898	National Seating & Mobility, Inc.	3401 N. May Ave., STE 3401 A & C	Oklahoma City	OK	73112-6904	PENDING	PENDING
177	Sayre	62-1400785	1669959904	National Seating & Mobility, Inc.	117 N Keystone Ave	Sayre	PA	18840-1403	570710147	1007304120025
178	Santa Barbara	62-1400785	1235612607	National Seating & Mobility, Inc.	310 Pine Ave. STE A	Goleta	CA	93117-3735	570710152	Pending
180	Albuquerque	62-1400785	1093285330	National Seating & Mobility, Inc.	7216 Washington NE, STE F	Albuquerque	NM	87109-4514	0570710154	PENDING
181	The Bronx	06-1026214	1093280455	Hudson Home Health Care, Inc.	1513 Olmstead Ave	Bronx	NY	10462-4254	570710147	Pending
186	Ft Worth	62-1400785	1295299899	National Seating & Mobility, Inc.	5470 E Loop 820 Ste 110	Fort Worth	TX	76119-6515	PENDING	Not Submitted
188	Martinez	62-1400785	1447718994	National Seating & Mobility, Inc.	825 Arnold Drive Suite 112	Martinez	CA	94553-6837	0570710156	Pending
190	North Charlotte	62-1400785	1447719810	National Seating & Mobility, Inc.	8421 Old Statesville Road, Suite 18	Charlotte	NC	28269-1838	PENDING	PENDING

4DD

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

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

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

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Albertsons Pharmacy #0155

Physical Address: 2582 Idaho Street

City: Elko State: NV Zip Code: 89801

Telephone: TBD Fax: TBD

Toll Free Number: NA E-mail: rxlicenses@albertsons.com

Website: www.albertsons.com

Managing Pharmacist: Eric VanMeter License Number: 17356

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: Immunizations and Pet meds with prescription

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

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

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

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

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

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

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

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

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

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

Robert Gordon
Print Name of Authorized Person

11/21/2019
Date

Board Use Only	Date Processed: _____	Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DE

Parent Company if any: Albertsons Companies Inc

Mailing Address: 250 E. Parkcenter Blvd

City: Boise State: ID Zip: 83706

Telephone: 208-395-4301 Fax: 208-395-4158

Contact Person: Mike Wallace

For any corporation non publicly traded, disclose the following:

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

a) See attached officer list
Name Business Address

b) _____
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

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

3) What was the price paid per share? NA

List any physician shareholders and percentage of ownership.

Name: NA %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 7 pm Saturday 10 am 5 pm

Sunday 10 am 5 pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20061105524

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

I, Robert Gordon

Responsible Person of Albertsons 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.

Robert Gordon

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

Robert Gordon

Print Name of Authorized Person

11/21/2019

Date

Managing Pharmacist

Pharmacist Name: Eric VanMeter License #: 17356

Pharmacy Name: Albertsons LLC dba Albertsons Pharmacy #3489

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

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

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

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

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

Board Administrative Action: State: NV Date: 10/14/15 Case #: 15-022-RPH-B-S

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

11/21/19
Date

Albertson's LLC
FEIN 82-0184434
250 E. Parkcenter Blvd.
Boise, ID 83706
(208) 395-6200
Delaware Limited Liability Company; Incorporated/Formed 4/3/1969
Ownership/Control Disclosure Document

Officers of Albertson's LLC			
Name	**Title**	**Address**	**Phone**
Robert A. Gordon	Executive Vice President, General Counsel & Secretary	250 E. Parkcenter Blvd., Boise, ID 83706	(208) 395-6200
Robert B. Dimond	Executive Vice President & Chief Financial Office	250 E. Parkcenter Blvd., Boise, ID 83706	(208) 395-6200
Mark C. Panzer	Senior Vice President, Pharmacy, Health & Wellness	250 E. Parkcenter Blvd., Boise, ID 83706	(208) 395-6200
Gary R. Morton	Vice President, Treasurer & Assistant Secretary	250 E. Parkcenter Blvd., Boise, ID 83706	(208) 395-6200
Ownership Information	**5% or Greater Ownership Interests**	**Address**	**FEIN**
Albertsons Companies, Inc.	100% Owner of Albertson's LLC	250 E. Parkcenter Blvd., Boise, ID 83706	47-4376911

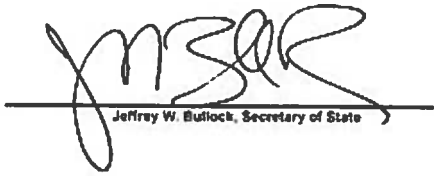
Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "ALBERTSON'S LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE NINETEENTH DAY OF NOVEMBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.





708424 8300

SR# 20198173074

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 204039252

Date: 11-19-19

Pharmacy Professional Services Department
250 E Parkcenter Blvd
Boise, ID 83706
(208)395-3200
(623)282-3882 fax

December 5, 2019

Nevada State Board of Pharmacy
431 W. Plumb Ln
Reno, NV 89509

To whom it may concern:

Re: New Pharmacy Application
Albertsons Pharmacy #155 located in Elko, Nevada

Please accept this letter and copy of my POA as the signed statement of explanation requirement of the application.
Enclosed you will find separate statements of explanation, with the final orders, for the questions on page 2 where we designated a "yes" answer.

Should you need any additional information or have any questions please don't hesitate to reach out to me.

Thank you

Julie Loftus
Pharmacy License Supervisor
Julie.loftus@albertsons.com
208-395-4320

CERTIFICATE OF AUTHORITY AND LIMITED POWER OF ATTORNEY

I, Shane Sampson, Chief Marketing & Merchandising Officer of Albertson's LLC, a Delaware limited liability company ("Company"), by authority granted to me under a standing resolution duly adopted by the Board of Managers on June 3, 2015, hereby delegate authority and grant a limited power of attorney to **Julie Loftus** individually, for and on behalf of the Company and its consolidated subsidiaries, to execute the following:

Make application to the various states and other governmental bodies for, and execute and deliver the documents necessary to acquire and maintain, all licenses, registrations, permits, and other documents relating to the provision of pharmacy services, as required by the issuing local, state, or federal governmental entity.

Notwithstanding this Certificate of Authority and Limited Power of Attorney, Julie Loftus individually remains subject to, and must comply with, any applicable approval and procedural requirements set forth in the Company's policy on legal review, approval and signing of agreements, as such policy may be amended from time to time.

This Certificate of Authority and Limited Power of Attorney shall continue in effect for the individual named above for so long as such individual remains in her present position (or any more senior position of authority) and maintains responsibility for the tasks or functions described herein, unless earlier modified or rescinded in writing.

Dated: November 16, 2015.

Shane Sampson
Chief Marketing & Merchandising Officer

I, Laura A. Donald, hereby certify that I am Vice President, Corporate & Business Law and Assistant Secretary of the Company; that the standing resolution duly adopted by the Board of Managers of the Company on June 3, 2015 is still, on this day, in full force and effect; that Shane Sampson is Chief Marketing & Merchandising Officer of the Company and that Shane Sampson has full right and authority to execute the above Certificate of Authority and Limited Power of Attorney.

Dated: November 17, 2015.

Laura A. Donald

Laura A. Donald
Vice President Corporate & Business Law
and Assistant Secretary

Albertsons Companies

Pharmacy Professional Services Department
250 E Parkcenter Blvd
Boise, ID 83706
(208)395-3200
(623)282-3882 fax

On January 3, 2018, Albertsons LLC dba Sav-on Pharmacy #536, located in Troutdale, Oregon, entered into a Consent Order with the Oregon Board of Pharmacy as a result of a floating technician who had not renewed her license. The individual had accidentally been classified as a pharmacy clerk and, as such, the division's annual review of personnel licenses mistakenly did not include hers. This resulted in an unlicensed individual performing the duties of a pharmacy technician without a pharmacy technician license. As a result, Sav-on Pharmacy #536 was ordered to pay a $4,500 civil penalty that had been stayed in a separate case (Case No. 2014-0298; Sav-on Pharmacy #570) for a similar violation that occurred in September of 2014 (which is outside the five year lookback period requested on the Nevada license application; please let us know if you would like additional information). In addition, Sav-on Pharmacy #536 also paid a $10,000 civil penalty ($50,000 total, with $40,000 stayed pending no further similar violations for three years) and as part of the stipulation, Albertsons must audit compliance with a Quality Assurance Plan at all Oregon drug outlets quarterly for a period of three years and submit quarterly reports to the Board. There are no additional restrictions placed on Sav-on Pharmacy #536's registration that would affect its ability to operate as a pharmacy in the State of Oregon.

RECEIVED
DEC 27 2017
OREGON BOARD OF PHARMACY

BEFORE THE BOARD OF PHARMACY
OF THE STATE OF OREGON

In the Matter of the Drug Outlet Registration of	)	Case No. 2016-0579
ALBERTSONS LLC dba: SAV-ON PHARMACY #536	)	CONSENT ORDER
Registrant	)	

WHEREAS, the Board of Pharmacy of the State of Oregon has filed a Notice of Proposed Disciplinary Action; Answer Required ("Notice"), hereby incorporated by reference, regarding the registrant in the above-captioned matter; and

WHEREAS, the above-noted Notice was duly served on the registrant as required by law; and

WHEREAS, the parties are desirous of resolving and settling those matters contained in the above-noted Notice without further proceedings thereon; and

WHEREAS, the registrant is aware of the right to a hearing with the assistance of counsel and the right to judicial review of the Board's decision, and hereby freely and voluntarily waives those rights; and

WHEREAS, the registrant admits that the facts alleged in the above-noted Notice are true, that legal cause exists pursuant to ORS 689.405 and ORS 689.445 for disciplinary action and imposition of a civil penalty by the Board; and

WHEREAS, the registrant consents to the disciplinary action as set forth herein;

The Board finds that the allegations in the Notice are true and hereby:

1. The registrant shall pay the Board the $4,500 civil penalty stayed in Case No. 2014-0298 Consent Order.

2. The registrant shall pay the Board a civil penalty in the amount of $50,000 for violations noticed in Case No. 2016-0579, with $40,000 stayed pending no similar violation at an Oregon registrant location for 3 years and compliance with this order.

3. The combined $14,500 civil penalty payment not stayed shall be made within ten days from the date this Consent Order becomes final. If registrant violates any term or condition of this Consent Order, the Board may take action to lift the stayed portion of the civil penalty.

4. The registrant shall submit a Quality Assurance Plan acceptable to the Board to correct violations as noted in Notice. Quality Assurance Plan, along with a copy of this order, to be

submitted within ten days from the date this Consent Order becomes final.

5. Registrant shall audit compliance with Quality Assurance Plan at all Oregon drug outlets quarterly for a period of three (3) years and submit quarterly reports on registrant compliance with Quality Assurance plan to the Board office. Quarterly report due dates will be determined once the QA Plan is approved by the Board. Quarterly reports are to be clearly identified with Case No. 2016-0579, with one copy to be filed with Pharmacist-in-Charge Self Inspection form on site, and one copy to be submitted to the Board office by certified mail (or other method approved by the Board in writing) and retain receipt of verification of delivery to the Board office.

6. The registrant must comply with all laws and rules regarding pharmacy practice.

7. Failure of the registrant to comply with the sanctions of this Consent Order may, after notice and hearing, result in further disciplinary action.

CONSENT

I hereby acknowledge that I am the authorized representative of registrant. On behalf of the registrant, I hereby acknowledge that I have read and understand the above-noted Notice and the terms of the Consent Order. I hereby acknowledge that I understand that the Consent Order with incorporated Notice is a public record and shall be available via the Board's online licensure verification; is available upon written request pursuant to public disclosure laws; and shall be reported to the National Practitioner Data Bank as required by federal law. I agree to the Board entering the Consent Order.

Authorized Representative — Date 12/22/17
ALBERTSONS LLC dba
Sav-On Pharmacy #536
Registrant (Reg. No. RP-0001883)

IT IS SO ORDERED.

BOARD OF PHARMACY
FOR THE STATE OF OREGON

Brianne Efremoff, Pharm.D, R.Ph., — Date 1/3/18
Compliance Director

BEFORE THE BOARD OF PHARMACY
OF THE STATE OF OREGON

In the Matter of the Drug OutletRegistration of	)	Case No. 2016-0579
ALBERTSONS LLC dba: SAV-ON PHARMACY #536	)	NOTICE OF PROPOSED DISCIPLINARY ACTION; ANSWER REQUIRED
Registrant	)	

Under the authority granted pursuant to ORS 689.135, 689.145, 689.335, 689.405 and 689.445, the Oregon Board of Pharmacy proposes to take disciplinary action against your Certificate of Registration No. RP-0001883 because Sav-On Pharmacy #536 violated the Oregon Pharmacy Act and the Board of Pharmacy rules as set forth below:

On 9/16/2014, Albertsons LLC entered into Consent Order 2014-0298 with the Oregon Board of Pharmacy. Violations admitted to in Case No. 2014-0298 included Albertsons LLC dba: Savon Pharmacy #570 employing, allowing, aiding, and abetting an unlicensed individual to perform the duties of a pharmacy technician without a pharmacy technician license at Albertsons LLC Eugene and Roseburg pharmacies. Sanction 1 of Consent Order 2014-0298 stayed $4,500 of their $5,000 civil penalty with the submission of a Quality Assurance Plan acceptable to the Board to correct violations as noted in Notice and with no similar violation at an Oregon outlet for 3 years.

From on or about 7/1/2016 to 12/19/2016, Sav-On pharmacies in OR, employed, allowed, aided, and abetted an unlicensed individual to perform the duties of a pharmacy technician without a pharmacy technician license.

The above conduct is contrary to accepted standards of practice and unprofessional conduct as defined by OAR 855-006-0020(f) and (j) and in violation of and grounds for discipline under OAR 855-025-0040(2), OAR 855-025-0035(2) and (3), OAR 855-041-1010(2), OAR 855-041-1040(7), ORS 689.486(5) and ORS 689.405(1)(a), (e)(B), (h), and (i).

Based on these alleged violations, the Board proposes to impose a civil penalty in the amount of $10,000 per violation, and impose $4,500 civil penalty stayed in Consent Order 2014-0298.

HEARING RIGHTS

The corporation is entitled to a hearing as provided by the Administrative Procedures Act (ORS chapter 183). An attorney must represent the corporation. If the corporation wishes to have a hearing, the corporation's attorney must file a written request for hearing with the Board within 21 days from the date this notice was mailed. The corporation's attorney may send or deliver a

request for hearing to:

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland, OR 97232
Fax: (971) 673-0002

If a request for hearing is not received within this 21-day period, the corporation's right to a hearing shall be considered waived.

If the corporation requests a hearing, the corporation's attorney will be notified of the time and place of the hearing. Before the commencement of the hearing, the corporation will be given information on the procedures, right of representation and other rights of parties relating to the conduct of the hearing.

If the corporation does not request a hearing within 21 days, or if it withdraws a hearing request, notifies the Board or Administrative Law Judge that it will not appear, or fails to appear at a scheduled hearing, the Board may issue a final order by default imposing discipline. If the Board issues a final order by default, it designates its file on this matter as the record.

ANSWER REQUIRED

Pursuant to OAR 855-001-0010 and OAR 855-001-0015, if you request a hearing you must also provide, within 21 days from the date this contested case notice was served, a written answer to the allegations set forth in this contested case notice. Your written answer must include an admission or denial of each factual matter alleged in the notice and a short and plain statement of each relevant affirmative defense you may have. Except for good cause, factual matters alleged in the notice and not denied in the answer shall be presumed admitted; failure to raise a particular defense in the answer will be considered a waiver of such defense; new matters alleged in the answer (affirmative defenses) shall be presumed to be denied by the agency; and evidence shall not be taken on any issue not raised in the notice and the answer.

Hearing Request and Answers:
Consequences of Failure to Answer
855-001-0015

(1) A hearing request, and answer when required, shall be made in writing to the Board by the party or his attorney and an answer shall include the following:

- (a) An admission or denial of each factual matter alleged in the notice;
- (b) A short and plain statement of each relevant affirmative defense the party may have.

(2) Except for good cause;

- (a) Factual matters alleged in the notice and not denied in the answer shall be presumed admitted;
- (b) Failure to raise a particular defense in the answer will be considered a waiver of such defense;
- (c) New matters alleged in the answer (affirmative defenses) shall be presumed to be denied by the agency; and

(d) Evidence shall not be taken on any issue not raised in the notice and the answer.

BOARD OF PHARMACY
FOR THE STATE OF OREGON

_____ 4/17/17
Brianne Efremoff, Pharm.D, R.Ph., Date
Compliance Director

DATE OF MAILING 4-18-2017

Pharmacy Professional Services Department
250 E Parkcenter Blvd
Boise, ID 83706
(208)395-3200
(623)282-3882 fax

On November 5, 2019, Albertsons LLC dba Sav-on Pharmacy #135, located in Texarkana, Texas, entered into a Board Order with the Texas Board of Pharmacy relating to a misfill event that occurred on or about January 30, 2018. The pharmacy's license was reprimanded and paid a fine of $3500. As part of the Order, a Continuous Quality Improvement Program has been developed for this location which will review all medication errors. No restrictions are on the pharmacy license.

AGREED BOARD ORDER #2019-01547

RE: IN THE MATTER OF
SAVON PHARMACY #135
(PHARMACY LICENSE #18610)

BEFORE THE TEXAS STATE
BOARD OF PHARMACY

On this day came on to be considered by the Texas State Board of Pharmacy (Board) the matter of pharmacy license number 18610 issued to Savon Pharmacy #135 (Respondent), 4415 West 7th, Texarkana, Texas 75501.

By letter dated June 21, 2019, the Board gave preliminary notice to Respondent of its intent to take disciplinary action. This action was taken as a result of an investigation which produced evidence indicating that Respondent may have violated:

Sections 551.003(19) and (26); 565.001(a)(1), (2), (12) and (13); and 565.002(a)(3) of the Texas Pharmacy Act, TEX. OCC. CODE ANN. Title 3, Subtitle J (2017); and

Sections 281.7(a)(3), (12) and (13); 291.31(1), (15), (16), (17), (20) and (32); 291.32(c)(1)(E) and (F); 291.32(c)(2)(B), (D), (E) and (H); 291.33(c)(1)(A) and (B); 291.33(c)(2)(A); 291.34(a); 291.34(c)(3)(G); 291.34(e)(2)(C); and 295.3(b) of the Texas Pharmacy Board Rules, 22 TEX. ADMIN. CODE (2018), in that allegedly:

COUNTS

(1) On or about January 30, 2018, Sahar Naim Abed, while acting as an employee (staff pharmacist) of Savon Pharmacy #135, 4415 West 7th Street, Texarkana, Texas 75501, dispensed doxepin 100 mg capsules to R.C., a 73-year-old patient, on a new electronically transmitted prescription calling for doxycycline 100 mg capsules. The prescription was incorrectly data entered into the pharmacy's data processing system by a pharmacy technician, and the data entry was incorrectly verified by Ms. Abed. The prescription vial was labeled 20 doxepin 100 mg capsule with directions to "take one capsule by mouth twice daily with food for 10 days." Patient R.C. took approximately six doses of the wrong drug as directed by the label, and experienced adverse effects, including disorientation, urinary retention, and exacerbation of a preexisting prostate condition. The prescription was assigned prescription number 6762459.

(2) On or about January 30, 2018, Sahar Naim Abed, while acting as an employee (staff pharmacist) of Savon Pharmacy #135, 4415 West 7th Street, Texarkana, Texas 75501, failed to evaluate and identify the clinically significant high dosage of the dispensed prescription described above in Count (1). Patient R.C. had not previously received a prescription for doxepin from the pharmacy. For adult patients, the recommended initial daily oral dosage of doxepin is 75 mg, and may be titrated upward to achieve a higher desired dose. The prescription as dispensed instructed patient R.C. to take an initial dosage

of 100 mg twice daily, resulting in an initial daily dosage of 200 mg, which is more than two-and-a-half times the recommended initial daily oral dosage.

(3) On or about January 30, 2018, Sahar Naim Abed, while acting as an employee (staff pharmacist) of Savon Pharmacy #135, 4415 West 7th Street, Texarkana, Texas 75501, failed to evaluate and identify the clinically significant drug-disease interactions of the dispensed prescription described above in Count (1). Patient R.C. had previously received an antihypertensive, namely lisinopril 2.5 mg tablets, from the pharmacy. It is recommended that doxepin be used with caution in patients, especially elderly patients, with hypertension, due to the increased risk for adverse cardiovascular effects. The pharmacy's data processing system alerted Ms. Abed that doxepin 100 mg tablets should be used with "extreme caution" given patient R.C.'s history of lisinopril use, and there is no documentation regarding the steps taken by Ms. Abed to avoid or resolve the problem or demonstrating that she consulted with the prescriber.

(4) On or about January 30, 2018, Sahar Naim Abed, while acting as an employee (staff pharmacist) of Savon Pharmacy #135, 4415 West 7th Street, Texarkana, Texas 75501, failed to evaluate and identify the clinically significant rational therapy-contraindications of the dispensed prescription described above in Count (1). Patient R.C. had previously received tamsulosin 0.4 mg capsules from the pharmacy, which is indicated for the treatment of the signs and symptoms associated with benign prostatic hyperplasia, including urinary retention. Doxepin is contraindicated in patients with severe urinary retention, and it is recommended that the drug be used with caution in patients with risk factors for urinary retention.

(5) On or about January 30, 2018, Sahar Naim Abed, while acting as an employee (staff pharmacist) of Savon Pharmacy #135, 4415 West 7th Street, Texarkana, Texas 75501, failed to provide verbal patient counseling to patient R.C. on the prescription described above in Count (1).

(6) On or about January 30, 2018, Savon Pharmacy #135, 4415 West 7th Street, Texarkana, Texas 75501, failed to maintain complete and accurate records of dispensing for the prescription described above in Count (1). Specifically, the patient medication record and daily dispensing log do not contain information that the prescription was dispensed to patient R.C.

An informal conference was held in the Board's office on September 10, 2019, with Nicholas Ryan LaBarbera, R.Ph., Divisional Pharmacy Manager, Albertson's Companies, Inc., on behalf of Respondent, and Nanette K. Beaird, Legal Counsel for Respondent, in attendance. The informal conference was heard by Board Members: Dennis F. Wiesner, R.Ph.; and Jenny Downing Yoakum, R.Ph; with Kerstin Arnold, General Counsel. Mary Martha Murphy, Staff Attorney, was also in attendance.

By signing this Order, Anthony Provenzano, Vice President, Pharmacy Compliance and Government Affairs, Albertson's Companies, Inc., on behalf of Respondent, and Respondent's counsel neither admit nor deny the truth of the matters previously set out in this Order, and agree that the Board has jurisdiction in this matter and waive the right to notice of hearing, formal administrative hearing, and judicial review of this Order.

The parties acknowledge that this Order resolves the allegations set forth herein, and agree to the terms and conditions set forth in the ORDER OF THE BOARD below.

ORDER OF THE BOARD

THEREFORE, PREMISES CONSIDERED, the Board does hereby ORDER that:

(1) Respondent's license is reprimanded.

(2) Respondent shall pay an administrative penalty of three thousand five hundred dollars ($3,500) due one hundred twenty (120) days after the entry of this Order.

(3) Respondent shall develop and implement policies and procedures for a Continuous Quality Improvement Program for purposes of preventing and handling dispensing errors. The Continuous Quality Improvement Program shall include pharmacist peer review in compliance with guidelines approved by Board staff. In addition, the policies and procedures for pharmacist peer review shall state that:

(a) The peer review committee will:

- review incident reports;
- determine what caused errors;
- make recommendations to correct the problem that caused the errors; and
- monitor the changes to determine if the changes have improved the operation of Respondent and reduced errors.

(b) The peer review committee must be comprised of at least two employees of Respondent, including the pharmacist-in-charge and other pharmacist(s) or personnel who are employees of Respondent. The committee shall not be solely comprised of a district or regional manager/supervisor and the pharmacist-in-charge and shall not be used for personnel evaluation purposes.

(c) The peer review committee will meet regularly, and no less than quarterly.

(d) The peer review committee will make a record indicating:

- date of meeting;
- location of meeting;
- names of persons attending the meeting;

- description of activities;
- discussion of problems in Respondent's operation (e.g., work flow, dispensing process);
- findings;
- description of recommendations; and
- review of actions or changes relating to individuals, systems, or processes made as a result of previous recommendations.

(4) Respondent shall submit a report and/or documentation of such policies and procedures to Board staff within one hundred twenty (120) days after the entry of this Order. Copies of forms used by Respondent to collect the data on errors committed at the pharmacy (i.e., incident report forms) must be submitted to Board staff, as well as any other peer review forms that have been developed by Respondent. Additionally, records of the peer review committee, as described in subparagraph (d) above, shall be maintained for two (2) years at the location of Respondent and made available for inspection by Board employees.

(5) Respondent shall be responsible for all costs relating to compliance with the requirements of this Order.

(6) Respondent shall allow Board staff to directly contact Respondent on any matter regarding the enforcement of this Order.

(7) Failure to comply with any of the requirements in this Order constitutes a violation and shall be grounds for further disciplinary action. The requirements of this Order are subject to the Texas Pharmacy Act, TEX. OCC. CODE ANN., Title 3, Subtitle J (2019), and Texas Pharmacy Board Rules, 22 TEX. ADMIN. CODE (2019).

And it is so ORDERED.

THIS ORDER IS A PUBLIC RECORD.

SIGNED AND ENTERED ON THIS 5th day of November, 2019.

MEMBER, TEXAS STATE BOARD OF PHARMACY

ATTEST:

Allison Vordenbaumen Benz, R.Ph., M.S.
Executive Director/Secretary
Texas State Board of Pharmacy

APPROVED AS TO FORM AND AGREED TO:

Anthony Provenzano
Vice President, Pharmacy Compliance and Government Affairs, Albertson's Companies, Inc.
On behalf of Savon Pharmacy #135

Nanette K. Beaird, Legal Counsel for Savon Pharmacy #135
Foley Gardere
Foley & Lardner LLP
600 Congress Avenue, Suite 3000
Austin, Texas 78701

APPROVED AS TO FORM:

Kerstin Arnold, General Counsel
Texas State Board of Pharmacy

Pharmacy Professional Services Department
250 E Parkcenter Blvd
Boise, ID 83706
(208)395-3200
(623)282-3882 fax

On September 21, 2018, Safeway Pharmacy #3836 (an Albertsons LLC store) entered into a Stipulation and Final Agency Order with the Colorado State Board of Pharmacy regarding multiple violations found during inspections over a four-year period. As a result of the settlement, Safeway Pharmacy #3836's registration will be on probation for a period of three years. As part of the probation, Albertsons has contracted with an independent consultant to audit the pharmacy on a quarterly basis to ensure compliance. There are not additional restrictions being placed on Safeway Pharmacy #3836's registration that would affect its ability to operate as a pharmacy in the State of Colorado.

On November 15, 2019, as a result of additional record keeping violations, Safeway Pharmacy #3836 entered into a new Stipulation and Final Agency Order with Colorado State Board of Pharmacy. The probation has been extended by one year.

BEFORE THE STATE BOARD OF PHARMACY

STATE OF COLORADO

Case No. 2019-3314

STIPULATION AND FINAL AGENCY ORDER

IN THE MATTER OF DISCIPLINARY PROCEEDINGS REGARDING THE IN-STATE PRESCRIPTION DRUG OUTLET REGISTRATION IN THE STATE OF COLORADO OF SAFEWAY PHARMACY #3836, REGISTRATION NO. PDO 441,

Respondent Pharmacy.

IT IS HEREBY STIPULATED AND AGREED by and between the Colorado State Board of Pharmacy ("Board") and Safeway Pharmacy #3836, ("Respondent Pharmacy") to resolve all matters pertaining to Board Case Number 2019-3314, as follows:

FINDINGS AND CONCLUSIONS

1. The Board has jurisdiction over Respondent Pharmacy, its registration as an in-state prescription drug outlet, and the subject matter of this Stipulation and Final Agency Order ("Final Agency Order") pursuant to provisions of the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act at Title 12, Article 280, C.R.S. (2019).

2. Respondent Pharmacy was originally registered in the State of Colorado on or about October 17, 2002, being issued registration #PDO 441, and has been so registered at all times relevant to this disciplinary action.

3. Respondent Pharmacy's address of record with the Board and current location is 200 Quebec St., #400, Denver, CO 80230.

4. Respondent Pharmacy admits these findings and hereby waives any further proof in this or any other proceeding before the Board regarding the following facts.

5. On September 18, 2018, Respondent Pharmacy entered into a Stipulation and Final Agency Order ("2018 Order"). The 2018 Order was entered into as a result of an inspection of Respondent Pharmacy on April 2, 2018, during which a Board inspector found nine (9) repeated deficiencies from previous inspections:

    a. All prescriptions for anabolic steroids were not labeled with an indication for use (two (2) prescriptions). This was a repeated deficiency from the 2016 and 2017 inspections.

b. Administration records did not include the site of administration (ten (10) or more patients). This was a repeated deficiency from the 2015, 2016, and 2017 inspections.

c. Administration records did not include the date the VIS was provided to the patient (nine (9) or more patients). This was a repeated deficiency from the 2016 and 2017 inspections.

d. Compounding records did not include the lot number of each ingredient used in a preparation and identity of pharmacist approving/checking the preparation (two (2) prescriptions). This was a repeated deficiency from the 2016 and 2017 inspections.

e. Transferred orders did not include the address of transferring pharmacy (one (1) prescription had no street, city, or state). This was a repeated deficiency from the 2015 and 2016 inspections.

f. A beyond-use date was assigned to a compounded preparation that exceeded what is allowed in Board Rule 21.10.80. Prescription numbers 6387271 (magic mouth wash) and 6410794 (rocky mountain oral rinse) had one-year BUD's, in the absence of stability studies. This was a repeated deficiency from the 2016 and 2017 inspections. Consequently, Respondent Pharmacy assigned a beyond use date to a compounded preparation that exceeded the expiration dates of individual ingredients used in the preparation (two (2) prescriptions).

g. Electronic practitioner signatures were used but are not acceptable for controlled substance orders (two (2) prescriptions). This was a repeated deficiency from the 2015 and 2017 inspections.

h. Invoices detailing the receipt of prescription drugs were not marked with a date of receipt (three (3) McKesson and three (3) Safeway prescriptions). This was a repeated deficiency from the 2015 and 2016 inspections.

i. Changes or clarifications to an order did not include the date contacted, identity of pharmacist or pharmacy intern, and name of person conveying change or clarification (two (2) prescriptions). This was a repeated deficiency from the 2015 inspection.

6. In an inspection of Respondent Pharmacy on May 10, 2019, a Board inspector found three repeated deficiencies:

   a. Electronic practitioner signatures were used but are not acceptable for controlled substances. This deficiency was repeated from the 2017 and 2018 inspections.

b. Transferred orders did not include the address of the transferring pharmacy. This was a repeated deficiency from the 2015, 2016, and 2018 inspections.

c. Changes or clarifications of orders failed to note the date contacted when obtaining the change or clarification with the prescribing practitioner. This was a repeated deficiency from the 2015 and 2018 inspections.

7. This Final Agency Order supersedes the 2018 Order and also includes case number 2018-2414.

8. Respondent Pharmacy admits that its conduct, as set forth above, constitutes violations of the following sections of the Colorado Revised Statutes and Board Rules and provides grounds for disciplinary action against Respondent Pharmacy's Colorado registration as a prescription drug outlet:

Colorado Revised Statutes

12-280-126. Unprofessional conduct - grounds for discipline.

(1) The board may take disciplinary or other action as authorized in section 12-20-404, after a hearing held in accordance with the provisions of sections 12-20-403 and 12-280-127, upon proof that the licensee or registrant:

(c) Has violated:

(II) The lawful rules of the board; or

(III) Any state or federal law pertaining to drugs;

(k) Has failed to meet generally accepted standards of pharmacy or pharmacy technician practice;

(m) Has violated any lawful board order.

12-280-127. Disciplinary actions. (1) The board may take disciplinary or other action as authorized in section 12-20-404 when the board determines that the applicant, licensee, or registrant has engaged in activities that are grounds for discipline under section 12-280-126.

* * *

21 CFR 1306.05. Manner and issuance of prescriptions. (d) A practitioner may sign a paper prescription in the same manner as he would sign a check or legal document (e.g., J.H. Smith or John H. Smith). Where an oral order is not permitted, paper prescriptions shall be written with ink or indelible pencil,

typewriter, or printed on a computer printer and shall be manually signed by the practitioner. A computer-generated prescription that is printed out or faxed by the practitioner must be manually signed.

* * *

Pharmacy Board Rules and Regulations

2.01.10. Information to Appear on Each Order. The following information must appear on each written or oral order except as provided for chart orders for hospitalized patients (hospital chart orders):

a. The date the order was compounded and dispensed;

b. The assigned serial number (hospital chart orders are exempt from this requirement);

c. The quantity dispensed if differs from the quantity ordered (LTCF chart orders are exempt from this requirement provided this information is recorded within another appropriate uniformly maintain and readily retrievable permanent record of the dispensing pharmacy);

d. In the case of a controlled substance order, the patient address, prescriber address, and prescriber's Drug Enforcement Administration (DEA) registration; and

e. Patient address, prescriber address, and prescriber DEA registration number need not appear on any type of order for a non-controlled substance prescription.

2.01.20. Additional Information. The following shall also appear on the prescription or LTCF chart order when appropriate:

a. Any change in or clarification of an order shall be documented on the order and shall bear the initials of the responsible pharmacist or intern, the date contacted and the name of the individual conveying such change or clarification.

2.01.53. The pharmacist receiving the transferred prescription order information shall:

Reduce the transferred information to writing or print; write or print the word "transfer" on the face of the transferred prescription order; and provide all information required by law or rule to be on the prescription order, including:

(9) The address and telephone number of the transferring prescription drug outlet.

* * *

9. The Board finds and concludes, and Respondent Pharmacy agrees, that based upon Respondent Pharmacy's above-described violations of the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act and relevant rules and regulations, the following discipline is just and appropriate under the circumstances.

DISPOSITION

10. Fine with Surcharge. Pursuant to section 12-280-127(5)(a), C.R.S., Respondent Pharmacy shall pay a fine of On Thousand Five Hundred Dollars and No Cents ($1,500.00). Respondent Pharmacy understands and acknowledges that, pursuant to section 24-34-108, C.R.S., the Executive Director of the Department of Regulatory Agencies may impose an additional surcharge of 15% of this fine. Respondent Pharmacy shall therefore pay a total amount of One Thousand Seven Hundred Twenty Five Dollars and No Cents ($1,725.00). The total amount shall be payable to the State of Colorado and shall be remitted in one lump sum to be included when Respondent Pharmacy submits this signed Final Agency Order to the Board.

11. Probation. Respondent Pharmacy's registration shall be placed on probation for a period of three (3) years. Credit toward satisfying the period of probation shall be given only during such periods of time that Respondent Pharmacy is in total compliance with all provisions of this Final Agency Order.

Terms of Probation

12. Practice Monitor. Upon commencement of Respondent Pharmacy's probation pursuant to this Final Agency Order and during the entire probationary period, Respondent Pharmacy shall be monitored by a Board-approved practice monitor ("Practice Monitor"). The Practice Monitor shall not have been previously engaged by Respondent Pharmacy for such services.

    a. Qualifications: The Practice Monitor must:

        i. Be a Colorado-licensed pharmacist in good standing;
        ii. Practice pharmacy at least eighty (80) hours per month;
        iii. Have no current or past Board discipline;
        iv. Not be in any way employed by Respondent Pharmacy or any company that owns or operates Respondent Pharmacy; and
        v. Otherwise have no financial or personal interest in Respondent Pharmacy.

    b. Board Approval. Within twenty (20) days of the effective date of this Final Agency Order, Respondent Pharmacy must submit, for the approval of the Board

or its designated authority during the ordinary course of business, the name of a qualified Practice Monitor with a completed application as provided by the Board, a current resume, and a letter from the applicant Practice Monitor stating that he or she has received a complete copy of this Final Agency Order, that he or she has read and understands its contents, that he or she agrees to serve as Respondent Pharmacy's Practice Monitor and to complete the Board's Practice Monitor reports as required.

If a Practice Monitor nominated by Respondent Pharmacy is not approved by the Board or its designated authority, the period of probation shall be tolled until such time as Respondent Pharmacy nominates another Practice Monitor, that Practice Monitor is approved by the Board or its designated authority, and the Practice Monitor begins monitoring under all the terms and conditions of this Final Agency Order. Respondent Pharmacy must submit the name of another qualified Practice Monitor for approval of the Board or its designated authority within ten (10) days of the Board's or its designated authority's rejection of the applicant Practice Monitor. Additionally, if Respondent Pharmacy is required to nominate a new Practice Monitor for any reason, the period of probation shall be tolled for any period of time during which a Practice Monitor is not monitoring Respondent Pharmacy. Respondent Pharmacy must submit the name of another qualified Practice Monitor for approval of the Board or its designated authority within ten (10) days of the existing Practice Monitor's resignation.

c. Duties and Responsibilities. Once approved by the Board or its designated authority, the Practice Monitor shall function as the eyes and ears of the Board. The Practice Monitor shall:

i. Conduct random (unscheduled) inspections once every three (3) months (quarterly) during the entire probationary period to determine whether Respondent Pharmacy's records and practices comply fully with the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act, Board rules and regulations, state and federal laws pertaining to drugs, and this Final Agency Order;

ii. Notify the Board by means of a written report, within seventy-two (72) hours of any random inspection that reveals evidence of a violation by Respondent Pharmacy of the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act, Board Rules and Regulations, state or federal laws pertaining to drugs, or this Final Agency Order;

iii. Prepare and submit to the Board quarterly written reports no later than the 15th day of January, April, July, and October, which detail the results of the random on-site inspections during the previous quarter throughout the duration of probation; and

iv. Prepare and submit to Respondent Pharmacy quarterly invoices which itemize all reasonable fees and costs associated with the monitoring of Respondent Pharmacy during the previous quarter. The subject invoices shall, in turn, be submitted to the Board no later than the 15th day of January, April, July, and October throughout the duration of probation.

13. **Other Requirements.** Through its undersigned Authorized Representative, Respondent Pharmacy acknowledges and agrees that, as a condition of this Final Agency Order and probation, Respondent Pharmacy shall:

a. promptly pay all its own fees and costs associated with this Final Agency Order;

b. comply fully with this Final Agency Order; and

c. comply fully with the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act, all Board rules and regulations, and any other state and federal laws and regulations related to pharmaceuticals and pharmacists in the State of Colorado.

14. **Violations.** Time is of the essence to this Final Agency Order. It is the responsibility of Respondent Pharmacy to take all appropriate steps to comply fully with this Final Agency Order. Respondent Pharmacy acknowledges and agrees that any violation of this Final Agency Order shall constitute a willful violation of a lawful Board order, may be sanctioned as provided under section 12-280-127(4), C.R.S., and may be sufficient grounds for additional discipline, including but not limited to revocation of its registration. The pendency of any suspension or disciplinary action arising out of an alleged violation of this Final Agency Order shall not affect the obligation of Respondent Pharmacy to comply with all terms and conditions of this Final Agency Order.

15. **Completion of Terms.** Respondent Pharmacy must make a written request to the Board to end the terms and conditions of this Final Agency Order. In any request, it shall be Respondent Pharmacy's sole responsibility to establish, through written and other documentation, that Respondent Pharmacy has met all terms of this Final Agency Order. Respondent Pharmacy's probation shall continue until the Board or its designated authority has verified that Respondent Pharmacy has completed all terms of this Final Agency Order. The Board will consider Respondent Pharmacy's request during the ordinary course of business.

16. **Advisements and Waivers.** Through its undersigned Authorized Representative, Respondent Pharmacy enters into this Final Agency Order freely and voluntarily, after having the opportunity to consult with legal counsel and/or choosing not to do so. Respondent Pharmacy acknowledges its understanding that it has the following rights:

a. To have a formal notice of hearing and charges served upon it;

b. To respond to said formal notice of charges;

c. to have a formal disciplinary hearing pursuant to sections 12-20-403, 12-280-126, and 12-280-127, C.R.S.; and

d. To appeal this Board order.

Respondent Pharmacy freely waives these rights, and acknowledges that such waiver is made voluntarily in consideration for Board's limiting the action taken against it to the sanctions imposed herein.

17. **Acknowledgments.** The undersigned Authorized Representative of Respondent Pharmacy has read this Final Agency Order in its entirety and acknowledges, after having the opportunity to consult with legal counsel and/or choosing not to do so, that Respondent Pharmacy understands the legal consequences and agrees that none of the terms or conditions herein is unconscionable. Respondent Pharmacy is not relying on any statements, promises or representations from the Board other than as may be contained in this Final Agency Order. Respondent Pharmacy further acknowledges that it is not entering into this Final Agency Order under any duress.

18. **Integration and Severability.** Upon execution by all parties, this Final Agency Order shall represent the entire and final agreement of and between the parties in this case. In the event any provision of this Final Agency Order is deemed invalid or unenforceable by a court of law, it shall be severed and the remaining provisions of this Final Agency Order shall be given full force and effect.

19. **Public Record.** Upon execution by all parties, this Final Agency Order shall be a public record, maintained in the custody of the Board.

20. **Effective Date.** This Final Agency Order shall become effective upon (a) mailing by first-class mail to Respondent Pharmacy at Respondent Pharmacy's address of record with the Board, or (b) service by electronic means on Respondent Pharmacy at Respondent Pharmacy's electronic address of record. Respondent Pharmacy hereby consents to service by electronic means if Respondent Pharmacy has an electronic address on file with the Board.

ACCEPTED AND AGREED BY

Respondent Pharmacy

Authorized Representative

Dated: 11/17/2014

Name/ Title

FINAL AGENCY ORDER

WHEREFORE, the within Stipulation and Final Agency Order is approved, accepted, and hereby made an Order of the Board.

Done and effective this 15 day of November, 2019.

State Board of Pharmacy

BY: _____
Dmitry Kunin
Program Director

CERTIFICATE OF SERVICE

This is to certify that I have duly served the within **STIPULATION AND FINAL AGENCY ORDER** upon all parties herein by electronic means or by depositing copies of same in the United States mail, first class postage prepaid, at Denver, Colorado, this 15th day of NOVEMBER 2019, addressed as follows:

Safeway Pharmacy #3836
Attn: Benjamin Herr, Pharmacy Manager
200 Quebec St, #400
Denver, CO 80203
Email: rxlicenses@albertsons.com

Charles Painter
Manager, Pharmacy Professional Services Dept.
Albertson's Companies
Email: Charles.Painter@albertsons.com

Agent of the Board

BEFORE THE STATE BOARD OF PHARMACY

STATE OF COLORADO

Case No. 2018-2414

STIPULATION AND FINAL AGENCY ORDER

IN THE MATTER OF DISCIPLINARY PROCEEDINGS REGARDING THE IN-STATE PRESCRIPTION DRUG OUTLET REGISTRATION IN THE STATE OF COLORADO OF SAFEWAY PHARMACY #3836, REGISTRATION NO. PDO 441,

Respondent Pharmacy.

IT IS HEREBY STIPULATED AND AGREED by and between the Colorado State Board of Pharmacy ("Board") and Safeway Pharmacy #3836 ("Respondent Pharmacy") to resolve all matters pertaining to Board Case Number 2018-2414, as follows:

FINDINGS AND CONCLUSIONS

1. The Board has jurisdiction over Respondent Pharmacy, its registration as an in-state prescription drug outlet, and the subject matter of this Stipulation and Final Agency Order ("Final Agency Order") pursuant to provisions of the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act at Title 12, Article 42.5, C.R.S. (2017).

2. Respondent Pharmacy was originally registered in the State of Colorado on or about June 30, 2004, being issued registration number PDO 441, and has been so registered at all times relevant to this disciplinary action.

3. Respondent Pharmacy's address of record with the Board and current location is 200 Quebec St., #400, Denver, CO 80230.

4. Respondent Pharmacy admits these findings and hereby waives any further proof in this or any other proceeding before the Board regarding the following facts.

5. During a Board inspection on April 2, 2018, the following repeated deficiencies occurred:

   a. All prescriptions for anabolic steroids were not labeled with an indication for use (two (2) prescriptions). This was a repeated deficiency from the 2016 and 2017 inspections.

   b. Administration records did not include the site of administration (ten (10) or more patients). This was a repeated deficiency from the 2015, 2016, and 2017 inspections.

c. Administration records did not include the date the VIS was provided to the patient (nine (9) or more patients). This was a repeated deficiency from the 2016 and 2017 inspections.

d. Compounding records did not include the lot number of each ingredient used in a preparation and identity of pharmacist approving/checking the preparation (two (2) prescriptions). This was a repeated deficiency from the 2016 and 2017 inspections.

e. Transferred orders did not include the address of transferring pharmacy (one (1) prescription had no street, city, or state). This was a repeated deficiency from the 2015 and 2016 inspections.

f. A beyond-use date was assigned to a compounded preparation that exceeded what is allowed in Board Rule 21.10.80. Prescription numbers 6387271 (magic mouth wash) and 6410794 (rocky mountain oral rinse) had one-year BUD's, in the absence of stability studies. This was a repeated deficiency from the 2016 and 2017 inspections. Consequently, Respondent Pharmacy assigned a beyond use date to a compounded preparation that exceeded the expiration dates of individual ingredients used in the preparation (two (2) prescriptions).

g. Electronic practitioner signatures were used but are not acceptable for controlled substance orders (two (2) prescriptions). This was a repeated deficiency from the 2015 and 2017 inspections.

h. Invoices detailing the receipt of prescription drugs were not marked with a date of receipt (three (3) McKesson and three (3) Safeway prescriptions). This was a repeated deficiency from the 2015 and 2016 inspections.

i. Changes or clarifications to an order did not include the date contacted, identity of pharmacist or pharmacy intern, and name of person conveying change or clarification (two (2) prescriptions). This was a repeated deficiency from the 2015 inspection.

6. Respondent Pharmacy admits that its conduct, as set forth above, constitutes violations of the following sections of the Colorado Revised Statutes and Board Rules and provides grounds for disciplinary action against Respondent Pharmacy's Colorado registration as a prescription drug outlet:

Colorado Revised Statutes

12-42.5-121. Labeling.

(2) Except as otherwise required by law, any drug dispensed pursuant to a prescription order must bear a label prepared and placed on or securely attached to the medicine container stating at least the name and address of the prescription drug outlet, the serial number and the date of the

prescription or of its dispensing, the name of the drug dispensed unless otherwise requested by the practitioner, the name of the practitioner, the name of the patient, and, if stated in the prescription, the directions for use and cautionary statements, if any, contained in the prescription.

12-42.5-123. Unprofessional conduct - grounds for discipline. (1) The board may suspend, revoke, refuse to renew, or otherwise discipline any license or registration issued by it, after a hearing held in accordance with the provisions of this section, upon proof that the licensee or registrant:

(c) Has violated:

(I) Any of the provisions of this Article, including commission of an act declared unlawful in section 12-42.5-126;

(II) The lawful rules of the board; or

(III) Any state or federal law pertaining to drugs;

(k) Has failed to meet generally accepted standards of pharmacy practice.

12-42.5-124. Disciplinary actions. (1) The board may deny or discipline an applicant, licensee, or registrant when the board determines that the applicant, licensee, or registrant has engaged in activities that are grounds for discipline.

12-42.5-126. Unlawful acts - civil fines. (1) It is unlawful:

(g) To sell, compound, dispense, give, receive, or possess any drug or device unless it was sold, compounded, dispensed, given, or received in accordance with sections 12-42.5-118 to 12-42.5-122.

18-18-306. Records of registrants.

Persons registered to manufacture, distribute, or dispense controlled substances under this part 3 shall keep records and maintain inventories in conformance with the record keeping and inventory requirements of federal law and with any additional rules adopted by the board or department.

Pharmacy Board Rules and Regulations

2.01.20. Additional Information. The following shall also appear on the prescription or LTCF chart order when appropriate:

a. Any change in or clarification of an order shall be documented on the order and shall bear the initials of the responsible pharmacist or intern, the date contacted and the name of the individual conveying such change or clarification.

2.01.53. The pharmacist receiving the transferred prescription order information shall:

Reduce the transferred information to writing or print; write or print the word "transfer" on the face of the transferred prescription order; and provide all information required by law or rule to be on the prescription order, including:

(9) The address and telephone number of the transferring prescription drug outlet.

11.01.00. Records in General. All outlets registered and/or licensed by the Board shall maintain such records and inventories of prescription drugs as may be required by these rules or any other state or federal law or rule pertaining to such drugs. Such records shall be maintained on a current basis and shall be complete and accurate for all drugs which the outlet manufactures, receives, dispenses, distributes or otherwise disposes of in any other manner. Records and inventories of controlled substances shall be deemed to be "complete" only if each individual record and inventory contains all required information regarding each specific transaction, and if the set of records and inventories contains all information and documents requires to be kept by state and federal laws, and rules. A record or inventory shall be deemed to be "accurate" only if it is a complete, true and factual statement regarding or reflecting each specific transaction. A set of records or inventories shall be deemed to be "accurate" only if they are complete, and when considered as a whole, they demonstrate that the controlled substances and/or the records and inventories pertaining thereto have been handled in compliance with all applicable laws or rules and that all such controlled substances are properly accounted for.

All such records shall be retained for a period of at least two years after the date of any transaction relating to such record or inventory by any process providing an exact duplicate of the original order in a reproducible quality acceptable to the Board. Records shall be retained in a format that cannot be altered.

Records on an automated data processing system or subsequent storage of such records must be immediately retrievable (via monitor display or hard copy printout). Upon written Board approval, outlets capable of meeting the above standards may not be required to retain the original prescription order or LTCF chart order for non-controlled drugs.

11.06.10. Records of receipts of prescription drugs and controlled substances shall contain the following information for each such substance received:

e. Date received.

19.01.40. Recordkeeping.

a. The following information must be maintained by the prescription drug outlet for three years for each dose of vaccine or immunization administered:

(3) The date of the administration and site of injection of the immunization or vaccine;

(9) The date the VIS was provided.

21.00.10. Limitations and Record-Keeping.

b. No expired components may be used in compounding. No component may be used which will expire prior to the beyond-use date of the final compounded product. No expired final compounded product shall be dispensed or distributed.

21.10.60. Components.

a. Compounding personnel shall ascertain that ingredients for compounded products are in compliance with rule 21.00.10(b) and are of the correct identity and appropriate quality using the following information: vendors' labels, labeling, certificates of analysis, direct chemical analysis, and knowledge of compounding facility storage conditions. No expired components may be used in compounding. No component may be used which will expire prior to the beyond-use date of the preparation.

21.10.80. Storage and Beyond-Use Dating.

a. Completed compounded preparations that are not immediately dispensed or distributed shall be stored according to the guidelines in the formulation record.

b. In the absence of stability information that is applicable to the lowest and highest dose or concentration of a specific preparation compounded at the outlet, the following maximum beyond-use dates are to be used for non-sterile compounded preparations that are packaged in tight, light-resistant containers and stored at controlled room temperature unless otherwise indicated.

(1) For non-aqueous liquids and solid formulations

(a) Where the manufactured drug product is the source of the active ingredient, the beyond-use date shall not exceed 25% of the time remaining until the product's expiration date or 6 months, whichever is earlier;

(b) Where a USP/NF substance is the source of active ingredient, the beyond-use date shall not be greater than 6 months;

(2) For water-containing oral formulations prepared from ingredients in solid form, regardless of whether an ingredient contains water or water by itself is an ingredient, the beyond-use date shall not be greater than 14 days when stored at cold temperatures;

(3) For intranasal formulations, the beyond-use date shall not be greater than 30 days;

(4) For all other formulations, including topical, dermal, mucosal, liquids and semi-solid formulations, the beyond-use date shall not be greater than the intended duration of therapy or 90 days;

(5) The beyond-use date limits may be exceeded when there is supporting valid scientific stability information that is directly applicable to the specific preparation. This information shall be retained on-site at the outlet and be available for inspection.

21.11.00. Compounding Record.

a. For each compounded product prepared, a record shall be maintained and available for inspection for two years on the original order, or on a separate, uniform, and readily retrievable record documenting the following:

(4) Sources, lot numbers, and expiration dates of each component;

(7) Name of the pharmacist who approved the preparation.

7. The Board finds and concludes, and Respondent Pharmacy agrees, that based upon Respondent Pharmacy's above-described violations of the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act and relevant rules and regulations, the following discipline is just and appropriate under the circumstances.

DISPOSITION

8. **Probation**. Respondent Pharmacy's registration shall be placed on probation for a period of three (3) years. Credit toward satisfying the period of probation shall be given only during such periods of time that Respondent Pharmacy is in total compliance with all provisions of this Final Agency Order.

Terms of Probation

9. **Practice Monitor**. Upon commencement of Respondent Pharmacy's probation pursuant to this Final Agency Order and during the entire probationary period,

Respondent Pharmacy shall be monitored by Affiliated Monitors, Inc. ("AMI"), or another Board-approved practice monitor ("Practice Monitor").

a. Qualifications: The Practice Monitor must:

   i. Be a Colorado-licensed pharmacist in good standing;
   ii. Practice pharmacy at least eighty (80) hours per month;
   iii. Have no current or past Board discipline;
   iv. Not be in any way employed by Respondent Pharmacy or any company that owns or operates Respondent Pharmacy; and
   v. Otherwise have no financial or personal interest in Respondent Pharmacy.

b. Board Approval. Within twenty (20) days of the effective date of this Final Agency Order, Respondent Pharmacy must submit, for the approval of the Board or its designated authority during the ordinary course of business, AMI or the name of another qualified Practice Monitor with a completed application as provided by the Board, a current resume, and a letter from the applicant Practice Monitor stating that he or she has received a complete copy of this Final Agency Order, that he or she has read and understands its contents, and that he or she agrees to serve as Respondent Pharmacy's Practice Monitor and to complete the Board's Practice Monitor reports as required.

   If a Practice Monitor nominated by Respondent Pharmacy is not approved by the Board or its designated authority, the period of probation shall be tolled until such time as Respondent Pharmacy nominates another Practice Monitor, that Practice Monitor is approved by the Board or its designated authority, and the Practice Monitor begins monitoring under all the terms and conditions of this Final Agency Order. Respondent Pharmacy must submit the name of another qualified Practice Monitor for approval of the Board or its designated authority within ten (10) days of the Board's or its designated authority's rejection of the applicant Practice Monitor. Additionally, if Respondent Pharmacy is required to nominate a new Practice Monitor for any reason, the period of probation shall be tolled for any period of time during which a Practice Monitor is not monitoring Respondent Pharmacy. Respondent Pharmacy must submit the name of another qualified Practice Monitor for approval of the Board or its designated authority within ten (10) days of the existing Practice Monitor's resignation.

c. Duties and Responsibilities. Once approved by the Board or its designated authority, the Practice Monitor shall function as the eyes and ears of the Board. The Practice Monitor shall:

   i. Conduct random (unscheduled) inspections once every three (3) months (quarterly) during the entire probationary period to determine whether Respondent Pharmacy's records and practices comply fully with the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act, Board rules and regulations, state and federal laws pertaining to drugs, and this Final Agency Order;

ii. Notify the Board by means of a written report, within 72 hours of any random inspection that reveals evidence of a violation by Respondent Pharmacy of the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act, Board Rules and Regulations, state or federal laws pertaining to drugs, or this Final Agency Order;

iii. Prepare and submit to the Board quarterly written reports no later than the 15th day of January, April, July, and October, which detail the results of the random on-site inspections and audits during the previous quarter throughout the duration of probation; and

iv. Prepare and submit to Respondent Pharmacy quarterly invoices which itemize all reasonable fees and costs associated with the monitoring of Respondent Pharmacy during the previous quarter. The subject invoices shall, in turn, be submitted to the Board no later than the 15th day of January, April, July, and October throughout the duration of probation.

10. Other Requirements. Through its undersigned Authorized Representative, Respondent Pharmacy acknowledges and agrees that, as a condition of this Final Agency Order and probation, Respondent Pharmacy shall:

a. promptly pay all its own fees and costs associated with this Final Agency Order;

b. comply fully with this Final Agency Order; and

c. comply fully with the Pharmacists, Pharmacy Businesses, and Pharmaceuticals Act, all Board rules and regulations, and any other state and federal laws and regulations related to pharmaceuticals and pharmacists in the State of Colorado.

11. Violations. Time is of the essence to this Final Agency Order. It is the responsibility of Respondent Pharmacy to take all appropriate steps to comply fully with this Final Agency Order. Respondent Pharmacy acknowledges and agrees that any violation of this Final Agency Order shall constitute a willful violation of a lawful Board order, may be sanctioned as provided under §12-42.5-124(4), C.R.S., and may be sufficient grounds for additional discipline, including but not limited to revocation of its registration. The pendency of any suspension or disciplinary action arising out of an alleged violation of this Final Agency Order shall not affect the obligation of Respondent Pharmacy to comply with all terms and conditions of this Final Agency Order.

12. Completion of Terms. Respondent Pharmacy must make a written request to the Board to end the terms and conditions of this Final Agency Order. In any request, it shall be Respondent Pharmacy's sole responsibility to establish, through written and other documentation, that Respondent has met all terms of this Final Agency Order. Respondent Pharmacy's probation shall continue until the Board or its designated authority has verified that Respondent has completed all terms of this

Final Agency Order. The Board will consider Respondent Pharmacy's request during the ordinary course of business.

13. Advisements and Waivers. Through its undersigned Authorized Representative, Respondent Pharmacy enters into this Final Agency Order freely and voluntarily, after having the opportunity to consult with legal counsel and/or choosing not to do so. Respondent Pharmacy acknowledges its understanding that it has the following rights:

    a. To have a formal notice of hearing and charges served upon it;

    b. To respond to said formal notice of charges;

    c. To have a formal disciplinary hearing pursuant to §§12-42.5-123 and 12-42.5-124, C.R.S.; and

    d. To appeal this Board order.

    Respondent Pharmacy freely waives these rights, and acknowledges that such waiver is made voluntarily in consideration for Board's limiting the action taken against it to the sanctions imposed herein.

14. Acknowledgments. The undersigned Authorized Representative of Respondent Pharmacy has read this Final Agency Order in its entirety and acknowledges, after having the opportunity to consult with legal counsel and/or choosing not to do so, that Respondent Pharmacy understands the legal consequences and agrees that none of the terms or conditions herein is unconscionable. Respondent Pharmacy is not relying on any statements, promises or representations from the Board other than as may be contained in this Final Agency Order. Respondent Pharmacy further acknowledges that it is not entering into this Final Agency Order under any duress.

15. Integration and Severability. Upon execution by all parties, this Final Agency Order shall represent the entire and final agreement of and between the parties in this case. In the event any provision of this Final Agency Order is deemed invalid or unenforceable by a court of law, it shall be severed and the remaining provisions of this Final Agency Order shall be given full force and effect.

16. Public Record. Upon execution by all parties, this Final Agency Order shall be a public record, maintained in the custody of the Board.

17. Board Order. This Final Agency Order shall become an order of the Board when it is accepted and signed by the Program Director or authorized Board representative.

18. Effective Date. This Final Agency Order shall become effective upon (a) mailing by first-class mail to Respondent Pharmacy at Respondent Pharmacy's address of record with the Board, or (b) service by electronic means on Respondent Pharmacy at Respondent Pharmacy's electronic address of record with the Board. Respondent

Pharmacy hereby consents to service by electronic means if Respondent Pharmacy has an electronic address on file with the Board.

ACCEPTED AND AGREED BY

Respondent Pharmacy

_____ Dated: 9/7/18
Authorized Representative

Anthony Provenzano / VP Pharmacy Compliance
Name / Title

FINAL AGENCY ORDER

WHEREFORE, the within Stipulation and Final Agency Order is approved, accepted, and hereby made an Order of the Board.

Done and effective this 18th day of September, 2018.

State Board of Pharmacy

BY: _____
Joe Liber
Interim Program Director

CERTIFICATE OF SERVICE

This is to certify that I have duly served the within fully executed **STIPULATION AND FINAL AGENCY ORDER** upon all parties herein by electronic means or by depositing copies of same in the United States mail, first class postage prepaid, at Denver, Colorado, this 18th day of September 2018, addressed as follows:

By electronic mail to Respondent:
Safeway Pharmacy #3836
Attn: Kenneth DiMarco, R.Ph.
200 Quebec St., #400
Denver, CO 80230
Email: rxlicenses@albertsons.com

Anthony Provenzano, PharmD
Vice President, Pharmacy Compliance and Government Affairs
Albertsons Companies
Email: anthony.provenzano@albertsons.com

Charlie Painter
Manager, Pharmacy Professional Services Dept.
Albertson's Companies
Email: Charlie.Painter@albertsons.com

Linda Stanke
Agent of the Board

PAID
1150.00
1592571

Case View Screen

Case	2018-5103 (PUBLIC Internal Online)	Date Created	07/02/2018	Audit	
Status	Open In Board	Date Received	07/02/2018	Entry Items	
		Date Reopened	08/23/2018	Notes	
Note: Case is in compliance		Receiving Board	PHARMACY	Master Cases	
Respondent ID	1228181	Receiving Profession	Prescription Drug Outlet-Out-of-State	Participants	
Respondent	The Daily Dose	Receiving Department	Board	Timeline History	
Credential	OSP 0006936 The Daily Dose	Received By	Linda Stanko	Docket Report	
Address	◉ Public ○ Mail	Case Manager		Companion Case	
	The Daily Dose 4534 Westgate Blvd Ste 111 Austin, TX 78745-1468	Alleged Issues	Failure to Report		
		Case Nature	Informal		
Complainant ID					
Complainant	Anonymous				

Comments: Case opened due to failure to report manager change in timely manner

RECEIVED
SEP 14 2018
BY:_____

Pharmacy Professional Services Department
250 E Parkcenter Blvd
Boise, ID 83706
(208)395-3200
(623)282-3882 fax

On November 25, 2019, Albertsons LLC, d/b/a/ Sav-on Pharmacy #2798, Sav-on Pharmacy #709, Sav-on Pharmacy #3747, Sav-on Pharmacy #775, Sav-on Pharmacy #3713, Sav-on Pharmacy #714, Sav-on Pharmacy #775, Sav-on Pharmacy #3215 ("Albertsons") entered into a civil settlement agreement with the Drug Enforcement Administration ("DEA") for record keeping violations involving proper completion of DEA form 222. Albertsons paid a fine of $10,000 and must prepare and complete DEA form 222 as required by the DEA. There are no additional terms and conditions imposed on Albertsons, nor is Albertsons restricted in providing pharmacy services at these locations.

CIVIL SETTLEMENT AGREEMENT

This Civil Settlement Agreement ("Agreement") is entered by and between the United States Attorney's Office for the Western District of Louisiana, acting on behalf of the United States Department of Justice and the United States Drug Enforcement Administration ("DEA") (collectively referred to as the "United States") and DEA registrants Albertsons Pharmacy #2798 - BA7593482; Albertsons/Sav-on Pharmacy #709 – BA3075048; Albertsons/Sav-on Pharmacy #3747 – BA7088532; Albertsons/Sav-on Pharmacy #775 – BA6985228; Albertsons/Sav-on Pharmacy #3713 – BA2552114; Albertsons/Sav-on Pharmacy #714 – BA0282703; Albertsons/Sav-on Pharmacy #775 – BA6985228; Albertsons/Sav-on Pharmacy #3215 – BA2244123 operated by Albertson's LLC (collectively "Albertsons")(each a "Party" and collectively the "Parties").

RECITALS

A. Albertsons owns and operates numerous pharmacies that are or were registered with DEA as dispensers of Schedule II – V controlled substances under the provisions of the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §801 *et seq.* (Controlled Substances Act or "CSA").

B. While pharmacies are typically dispensers of drugs, when returning, transferring or disposing of controlled substances, they are bound by the requirements applicable to suppliers of controlled substances. 21 C.F.R. §1305.06. These requirements include completing the supplier's portion of the DEA 222 form, recording the number of containers and recording the date of shipping. See 21 C.F.R. §§1304.22 and 1305.13.

C. Albertsons acknowledges that its DEA-registered pharmacies were and are required to comply with the CSA and the regulations promulgated thereunder, including the requirements described in Paragraph B.

D. The United States contends that Albertsons failed to comply with the regulations in certain instances and that these failures subject Albertsons to civil penalties under 21 U.S.C. §§842(a)(10) and (c)(1)(B).

E. This Agreement is neither an admission of liability by Albertsons nor a concession by the United States that its claims are not well founded.

F. To avoid the delay, expense, inconvenience, and uncertainty of litigating the above-referenced claims, and in consideration of the mutual promises and obligations of this Agreement, the Parties agree and covenant as follows:

TERMS AND CONDITIONS

1. Paragraphs A-F set forth above are fully adopted herein.

2. For purposes of this Agreement, "Covered Conduct" shall mean the written preparation and completion of the DEA 222 forms identified on Appendix A.

3. Albertsons shall pay to the United States the total sum of TEN THOUSAND U.S. DOLLARS ($10,000.00) (the "Settlement Amount"), within seven (7) business days after the Effective Date of this Agreement by electronic funds transfer pursuant to the written instructions provided to Albertsons by the United States Attorney's Office for the Western District of Louisiana. Failure of Albertsons to pay the Settlement Amount as set forth herein will void this Agreement and, in such an event, the United States may pursue any and all available remedies against Albertsons for any of the Covered Conduct herein.

4. In consideration of the above and subject to the exceptions contained in paragraph 5, the United States fully and finally releases the Albertsons from any claims (including attorney's fees, costs and expenses of every kind and however denominated) that the United States has asserted or could have asserted against Albertsons for the Covered Conduct. Albertsons also agrees to fully and finally release the United States, including the DEA and its

agents, from any claims (including attorney's fees, costs and expenses of every kind and however denominated) related to the investigation, prosecution, and settlement of the Covered Conduct.

5. Notwithstanding the release given in Paragraph 4 of this Agreement, the United States specifically reserves and does not release:

i. Any administrative action by the DEA based on or related to the Covered Conduct, but which does not solicit or impose civil penalties;

ii. Any federal criminal liability;

iii. Any criminal, civil or administrative claim arising under Title 26, United States Code (Internal Revenue Code);

iv. Any liability under the False Claims Act, 31 U.S.C. §3729 or the Program Fraud Civil Remedies Act, 31 U.S.C. § 3801-3812;

v. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct; and/or

vi. Any liability based on obligations created by this Agreement.

6. Nothing in the Agreement constitutes an agreement by the United States concerning the characterization of the Settlement Amount for purposes of the Internal Revenue law, Title 26 of the United States Code.

7. This Agreement binds and is intended to benefit only the Parties. This Agreement is not intended to be, and shall not be interpreted to constitute, a release of any person or entity not identified or referred to herein.

8. Each Party shall bear its own legal or other costs incurred in connection with this matter, including the preparation, execution and performance of this Agreement.

9. Each Party and signatory to this Agreement represents that he, she or it freely and voluntarily enters into this Agreement without any degree of duress or compulsion.

10. This Agreement is governed by the laws of the United States. Each Party may seek judicial enforcement of this Agreement upon a material breach by the other Party. The Parties agree that the jurisdiction and venue for any dispute arising between and among the Parties will be the United States District Court for the Western District of Louisiana.

11. For the purposes of construing this Agreement, the Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not be construed against any Party for that reason in any subsequent dispute.

12. This Agreement constitutes the complete agreement between the Parties. All material representations, understandings, and promises of the Parties are contained in this Agreement. Each of the Parties expressly agrees and acknowledges that, in entering this Agreement, it is relying on only the statements and promises expressly set forth in this written Agreement. This Agreement cannot be amended, nor any provisions waived, except in writing and when signed by all Parties to this Agreement.

13. The undersigned individuals represent and warrant that they are fully authorized to execute this Agreement on behalf of the Parties listed below.

14. This Agreement may be executed in counterparts, including by facsimile, pdf, or other electronic form or signature, each of which constitutes an original and all of which constitute one and the same Agreement.

15. This Agreement is binding on Albertsons and its successors, transferees, heirs, and assigns.

16. The Parties may disclose the existence of and information about this Agreement to the public without restriction.

17. This Agreement shall be effective (final and binding) on the date of signature by the last signatory to the Agreement (the "Effective Date" of this Agreement).

ON BEHALF OF ALBERTSON'S LLC

DATED: November 20, 2019

Anthony Provenzano
Vice President, Pharmacy Compliance

ON BEHALF OF THE UNITED STATES

David C. Joseph
United States Attorney
Western District of Louisiana

By: _____ DATED: November 25, 2019
Melissa L. Theriot
Assistant United States Attorney
Western District of Louisiana

Appendix A

164422192

164693310

164693311

170262284

170262294

170262296

170812123

170812126

173104716

173182789

173182790

173182791

173182792

173658050

180771277

180771546

181996980

182778852

182778853

183305752

4EE

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: Smith Plastic Surgery Building, LLC

Physical Address: 7650 W. Sahara Ave

City: Las Vegas State: Zip Code: 89117 Telephone: (702) 838-2455 Fax: (702) 838-7055 Toll Free Number:_____

E-mail: info@smithsurgery.com

Website: smithsurgery.com

Managing Pharmacist: Mary Grear, RPH License Number: 10687

TYPE OF PHARMACY AND SERVICES PROVIDED

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

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

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

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

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

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

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

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

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

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

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

Lane F Smith, M.D. — Print Name of Authorized Person

Dec 13, 2019 — Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Mailing Address: 7650 W Sahara Ave

City: Las Vegas State: NV Zip: 89117

Telephone: (702) 838-2455 Fax: (702) 838-7055

Contact Person: Lane F. Smith, M.D

For any corporation non publicly traded, disclose the following:

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

a) Lane F. Smith, M.D. 100% 7650 W Sahara Ave Las Vegas NV 89117
Name Business Address

b) _____
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. 100% owner N/A LLC

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

List any physician shareholders and percentage of ownership.

Name: Lane F. Smith, M.D. %: 100

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:00 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: NV Business ID NV20151648004

APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: Lane F. Smith, M.D.

Business Name: Smith Plastic Surgery Building, LLC

Current Business Address: 7650 W. SAHARA AVE

City: Las Vegas State: NV Zip Code: 89117

Telephone: (702) 838-2455 Fax: (702) 838-7055

List any physician shareholders and percentage of ownership.

Name: Lane F. Smith, M.D. %: 100

Name: %:

Name: %:

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 5 pm Saturday ____ am ____ pm

Sunday ____ am ____ pm 24 Hours ____

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

NV Business ID: NV20151648004

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

I, Lane F Smith

Responsible Person of Smith Plastic Surgery Building 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

Lane F Smith, M.D.
Print Name of Authorized Person

Dec 13, 2019
Date

Managing Pharmacist

Pharmacist Name: Mary Grear, RPh License #: 10687

Pharmacy Name: Smith Plastic Surgery Buildings, LLC

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

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

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

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

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

Board Administrative Action: State: NJ Date: Apr 2002 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.

Mary Cerear, RPh
Signature

12/13/19
Date

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, Barbara K. Cegavske, the duly qualified and elected Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporations sole, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada standing Revised Statutes which are either presently in a status of good standing or were in good for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **SMITH PLASTIC SURGERY BUILDING LLC**, as a DOMESTIC LIMITED-LIABILITY COMPANY (86) duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since 10/28/2015, and is in good standing in this state.

I further certify that the above DOMESTIC LIMITED-LIABILITY COMPANY (86) has its formation document and no amendments on file in this office as of the date of this certificate.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on 12/11/2019.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Certificate Number: B20191211433623
You may verify this certificate online at http://www.nvsos.gov

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE
for a Pharmacy or Wholesaler located in Nevada

Date 12/13/19

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 ASC Pharmacy
Nature of Pharmacy or Wholesaler

Smith Plastic Surgery Building LL
Name and Address of Business for Which Designated Representative Is Requested

7650 W. Sahara Avenue Las Vegas, NV 89117
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Smith | Lane | Fielding
Last Name | First Name | Middle Name

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

Cascade Creek Lane | Las Vegas, NV 89113
Present Residence Address-Street or RFD | City | State/Zip

7650 W. Sahara Ave | Dates | Las Vegas | NV 89117
Present Business Address | City | State/Zip

Medical Doctor | Jan 2019- Dates pres. | Las Vegas | NV 89117
Present Position with the Pharmacy or Wholesaler

Phone:
Residence
Business

/ / 19[illegible]
Date of Birth | Place of Birth (City, County, State)

56 | Male
Age | Social Security Number | Sex

Blue | Auburn | White | 220 | Med. | 6' 4"
Color of Eyes | Color of Hair | Complexion | Weight | Build | 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.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial JF

MARITAL INFORMATION-Continued

A. **Current Marriage** Aug 30, 2018 (Date) Las Vegas, Clark, NV (City, County and State)

Spouse's full name (Maiden) Bree Jame S.S. No

Date of Birth Place of Birth

Resident address Cascade Creek Lane (Street) LV (City) NV (State) 89113 (Zip)

Telephone: Residence (ness) (702) 326-3903

Spouse's employer N/A Self-employed Occupation Model

Address of employer Cascade Creek Lane (Street) LV (City) NV (State) 89113 (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
Marcelle Smith	Oct 10, 1993	July 30, 1986		Salt Lake City Salt Lake County, Utah

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

Name	Street	City	State	Zip	Telephone
	E 2150 S	Bountiful	Utah	84010	

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
Lane F Smith,		Galveston TX	Reside
Kevin Smith,		Sandy Utah	Reside
Cadence Smith,		SLC, Utah	N 160 W Layton, UT 84041

B. Child Support Information:

Please mark the appropriate response:

☐ 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

FAMILY INFORMATION-Continued

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

Name ~~Utah~~ Wyoming Family Support

Address Unavailable

Contact person N/A

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	Lane Smith M.D.		Bridger Blvd Sandy, Utah	
Mother	Val Smith		Bridger Blvd Sandy, Utah	
Father-in-Law	~~Unknown~~ Wes James	dead	Unknown	Unknown
Mother-in-Law	Stacy Lynn Stelly	Unknown		Unknown

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
	Michelle Smith McComber			Pres of Utah Med Society
Spouse	Stan McComber			
	Renee Smith			Physician
Spouse	N/A			
	Joe Smith			salesperson
Spouse	Joy Smith			
	Evan Smith			Release Train engineer
Spouse	Janae Smith			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	James E Moss	Sandy Utah		Yes ☒ No ☐
High School	Brighton High School	Sandy, Utah		Yes ☒ No ☐
College University	University of Utah Medical School			Yes ☒ No ☐
Other	and undergraduate			Yes ☒ No ☐

Type of degree obtained, if any M.D.

College or university where obtained University of Utah

Applicant's initial JS

Siblings

Angie MC Farland	homemaker
Spouse Eric	
Stephanie Ramsey	customer service
Spouse Jake	
Cherise Romney	life coach
Spouse Preston	

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☐ No ☒

Branch ..... Date of entry-active service .....

Date of separation ..... Type of discharge .....

Rating at separation ..... Serial number .....

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 SLake State Utah Date registered 1982

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

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 ☐ as a Medical Doctor

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☑ No ☐ as a Medical Doctor

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
Lorin Smith	brother	deceased		on July 7, 2018

Applicant's initial .....

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

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
Caralyn Brook	Dec 2, 2019		Clark Cty	Ongoing

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
Same as above		
Caralyn Brook	Dec 2, 2019	Clark Ongoing

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
	Cascade Creek Lane	Las Vegas	NV
	Mayo clinic Residents	Rochester	MN USA
	Cave Valley Way	Bountiful	Utah 84010
	Orchard Lane	Palo Alto	California USA
	102 Turpin	Galveston	TX
	2685 Bridger Blvd.	Sandy	UT 84092

Applicant's initial .....

8. EMPLOYMENT:

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

2001 until Present Medical Doctor

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
2001 to Present	7650 W. Sahara Ave, 89117	Self 60+ Per week
Title	**Description of Duties**	**Name of Supervisor**
Plastic Surgeon		Self

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
2004	Mayo Clinic, Rochester MN	60+
Title	**Description of Duties**	**Name of Supervisor**
Medical Doctor		Ulnis BITE

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Self	Medical Doctor	60+ Per Week
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
7-94 - 7-99	Layton Utah	60+ Per Week
Title	**Description of Duties**	**Name of Supervisor**
M.D	Medical Doctor	Self

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
93-94	Stanford University Palo Alto	60+ Per wk
Title	**Description of Duties**	**Name of Supervisor**
	Associate Professor	Richard Goode

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
89-93	University of Texas Medical Branch, Galveston	
Title	**Description of Duties**	**Name of Supervisor**
	Resident Physician	Bypass Bailey M.D

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	**Description of Duties**	**Name of Supervisor**

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 J. Minoli, M.D. Home	7650 W Sahara Ave,	Las Vegas,	NV	89117		10yrs
Employer Self Business						
Name Shoib Myint DO Home	7650 W Sahara Ave,	Las Vegas,	NV	89117		
Employer Self Business						
Name Michael Crowley M.D Home						
Employer Smith Plastic Business	7650 W Sahara Ave,	Las Vegas,	NV	8911-		
Name Kristine Maxwell Home	9 Via De Cortona	Henderson	NV			
Employer Self Business						
Name William Arzoll M.D. Home						
Employer M.D - Business	7650 W Sahara Ave	Las Vegas,	NV	8911-		

10. 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

11. 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.

12. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☒ No ☐ IC of the Medical Board

13. 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: To meet w/ Board cleared on the event

Applicant's initial JS

14. 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 ☑

15. 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 ☑

16. 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 ☑

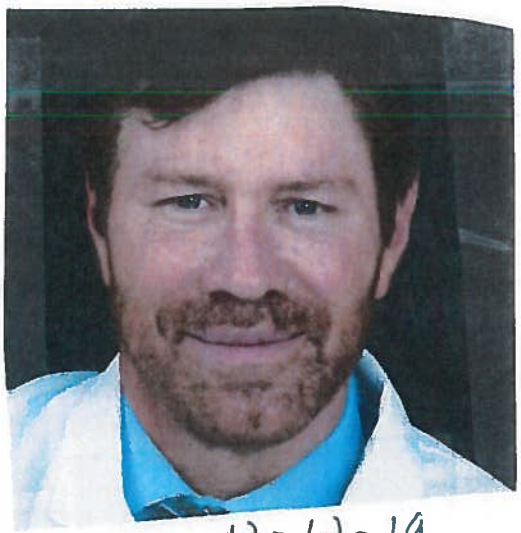
17. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a wholesaler Yes ☐ No ☑

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

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler? Yes ☐ No ☑

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☐ No ☑

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours? Yes ☐ No ☑



Date of photograph 12-12-19

Applicant's initial JS

STATE OF NEVADA
ss.

COUNTY OF CLARK

I, Lane F. Smith, M.D., 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 wholesaler 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 Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler 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 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 wholesaler in the State of Nevada.

Original Signature of Applicant MD

STATE OF NEVADA
COUNTY OF CLARK

Subscribed and Sworn to before me this 13TH day of DECEMBER, 2019

Notary Public

CARL ROSS
Notary Public State of Nevada
No. 04-93270-1
My Appt. Exp. Nov. 5, 2020

(seal)

Applicant's initial

ADDITIONAL INFORMATION

Applicant's initial .....

NEVADA

STATE BOARD OF PHARMACY

Pharmacist

Expires: 10/31/2021

STATUS: Active

License Type: Pharmacist

License #: 10687

THE UNDER-NOTED HAVING PAID STATUTORY FEE IS HEREBY LICENSED

Mary R. Grear

NONTRANSFERABLE

POST THIS LICENSE PROMINENTLY IN A CONSPICUOUS PLACE

4FF

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **non-transferable checks 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.

virtual manufacturer

☒ New Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH_____

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

☒ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7

☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: **Eton Pharmaceuticals, Inc.**

Physical Address: **21925 W. Field Parkway, Suite 235**

City: **Deer Park** State: **IL** Zip Code: **60010**

Telephone Number: **(847) 805-1026** Fax Number: **(847) 620-0625**

Toll Free Number: _____

E-mail: **dradosavljevic@etonpharma.com** Website: **etonpharma.com**

Facility Manager: **Danka Radosavljevic**

Professional qualifications and experience of facility manager: **12 years experience in pharmaceutical industry in QC, PD, and QA**

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers

☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☐ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices

☐ Poisons or Chemicals ☐ Veterinary Legend Drugs

☐ Controlled Substances (include copy of DEA)

☒ Other: **Eton will never physically handle or distribute non-controlled prescription drugs, but rather manage the manufacture and distribution of non-controlled prescription drugs through a CMO and 3PL**

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership

Is your company VAWD certified by NABP? Yes ☐ No ☒
(If yes, provide a copy of the certificate)

Licensed as Manufacturer by the FDA? Yes ☐ No ☒
(If yes, provide a copy of your FDA registration)

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 ☒

List the top 4 suppliers your company has been associated with regards to pharmaceutical products that were sold, dispensed or distributed with the last year.

MO
Name: **Sintetica S.A.**
Address: **Via Penate 5, Mendrisio, TI 6850, Switzerland**

3PL
Name: **Eversana Life Science Services, LLC**
Address: **4580 Mendenhall Rd Memphis, TN 38141**

Name:
Address:

Name:
Address:

A licensee is not required to have a Nevada State Business License, however, if you do, please provide the number: **N/A**

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 ☒

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

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.

Sean Brynjelsen

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

Sean Brynjelsen

Print Name of Authorized Person

10/22/2019

Date

Board Use Only	Date Processed:_____	Amount: 500⁻

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: **Delaware**

Parent Company if any: **No parent company**

Corporation Name: **Eton Pharmaceuticals, Inc.**

Mailing Address: **21925 W Field Parkway, Suite 235**

City: **Deer Park** State: **IL** Zip: **60010**

Telephone: **(847) 805-1026** Fax: **(847) 620-0625**

Contact Person: **Danka Radosavljevic**

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: **04/27/2017** (Delaware) Effective Date with SEC: 11/09/18

Registration number issued: 0001710340 (CIK) Commission File No: 001-38738

Stock Exchange: NASDAQ under trading symbol "ETON"

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

Include with the application for a 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. See attached.

eTon
PHARMACEUTICALS

Eton Pharmaceuticals, Inc. Facility Description:

Eton Pharmaceuticals, Inc is a virtual manufacturer located in Deer Park, Illinois. The Illinois Department of Financial and Professional Regulation currently does not have a license classification for "Virtual Manufacturer." However, an inspection was at the Deer Park location on October 4, 2018. After passing site inspection, Eton was licensed as a "Wholesale Drug Distributor."

Eton received FDA approval for **phenylephrine hcl** (Biorphen®) on October 21, 2019. Eton will direct sale of the prescription drug, but will not physically possess product. All manufacturing activities are outsourced to contract manufacturers (CMO), and all distribution activities are coordinated by third-party logistics providers (3PL).

Records:

All records related to manufacturing are maintained by the CMO and all records related to distribution are maintained by the 3PL, in compliance with all applicable rules and regulations.

Personnel:

All facility personnel training requirements are administered by the CMO and 3PL and are performed in a manner that ensures prescriptions drug quality, safety, and security will be maintained at all times as required by all applicable laws and regulations.

Security:

Facility security is maintained by the CMO and 3PL in compliance with all applicable rules and regulations.

3PL Information:

Eversana Life Science Services, LLC (formerly Dohmen Life Science Services, LLC)
4580 Mendenhall Rd
Memphis, TN 38141

Contact Person:
Emily Becker
(303) 952-7261

CMO Information:

Sintetica S.A.
Via Penate 5
Mendrisio, TI
6850, Switzerland (CHE)
FDA Establishment Identifier: 3004058163

US Agent Contact Person:
Craig Kruman
(248) 538 5150

eTon
PHARMACEUTICALS

State Licensure List

STATE	LICENSE NUMBER
Alabama	195788
Arkansas	WD05160
Arizona	*Pending*
Connecticut	CSM.0001660-OOS
Delaware	*Pending*
District of Columbia	*Pending*
Florida	*Pending*
Georgia	*Pending*
Idaho	*Pending*
Iowa	*Pending*
Illinois (Home State)	004004606
Kansas	5-110704
Louisiana	9513
Maryland	D06670
Michigan	*Pending*
Minnesota	*Pending*
Mississippi	*Pending*
Montana	*Pending*
New Hampshire	06781
New Jersey	*Pending*
New Mexico	*Pending*
New York	37185
North Carolina	*Pending*
North Dakota	Whol2232
Ohio	*Pending*
Oklahoma	88-M-6085
Oregon	*Pending*
South Carolina	*Pending*
South Dakota	*Pending*
Tennessee	0000005459
Texas	*Pending*
Utah	*Pending*
Vermont	*Pending*
Washington	PHWH.FX.61017675
West Virginia	MR0551894

eTon
PHARMACEUTICALS

DRUG PRODUCT

1. Phenylephrine HCl (Biorphen)
    a. NDA Number: 212909
    b. Labeler Code: 71863
    c. NDC Number: 71863-202-06

File Number 7142-058-2

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ETON PHARMACEUTICALS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON SEPTEMBER 29, 2017, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* OCTOBER *A.D.* 2019 .

Authentication #: 1928101544 verifiable until 10/08/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Illinois Department of Financial and Professional Regulation

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA
ETON PHARMACEUTICALS INC	Deer Park, IL 60010	•

License

License Information

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
004004606	LICENSED WHOLESALE DRUG DISTRIBUTOR	ACTIVE	10/04/2018	10/04/2018	12/31/2020	N

Generated on: 10/8/2019 9:33:04 AM

eTon
PHARMACEUTICALS

FDA Registration Exemption

Eton Pharmaceuticals received communication with the FDA on July 28, 2017 regarding exemption from registration. As Eton is virtual manufacturer, our company does not physically perform any drug manufacturing activity—and therefore, we are not required to register our establishment. See attached email correspondence.

From: CDER Electronic Drug Registration and Listing [mailto:EDRLS@fda.hhs.gov]
Sent: Friday, July 28, 2017 12:21 PM
To: Bharathi Devarakonda <BDevarakonda@etonpharma.com>; CDER Electronic Drug Registration and Listing <EDRLS@fda.hhs.gov>
Subject: RE: Do I need to Register?

Dear Bharathi Devarakonda,

Application holders / sponsors that perform no manufacturing processes, as defined in 21 CFR 207.1, are not required to register with FDA. Your contract manufacturers would have the obligation to register with FDA and list the drug.

Thanks,

Electronic Drug Registration and Listing Staff (jac)

Center for Drug Evaluation and Research

Office of Compliance

U.S. Food and Drug Administration

edrls@fda.hhs.gov

www.fda.gov/edrls



From: Bharathi Devarakonda [mailto:BDevarakonda@etonpharma.com]
Sent: Wednesday, July 19, 2017 12:29 PM
To: CDER Electronic Drug Registration and Listing
Cc: Bharathi Devarakonda
Subject: Do I need to Register?

Dear EDRLS Team,

Greetings.

I am Bharathi Devarakonda, Sr. V.P of Regulatory Affairs at Eton Pharmaceuticals. We are a newly formed pharmaceutical company with several products under development and manufacture stage. However, we use contract research and development organizations as well as contract manufacturing organizations to perform product development and registration batches manufacturing activities of our products. Eton will be the applicant/sponsor for subsequent filing of NDA/ANDAs for FDA review and approval of our products.

In this regard, I would like to know if our company Eton Pharmaceuticals needs to be registered with the FDA.

I appreciate your kind assistance in advance.

Sincerely,

Bharathi Devarakonda, Ph.D., RAC

Eton Pharmaceuticals, Inc.

Sr. Vice President

Product Development & Regulatory Affairs

21925 Field Parkway, Suite 235

Deer Park, IL 60010

C: 318-680-8343

E : bdevarakonda@etonpharma.com



eTon
PHARMACEUTICALS

Eton Pharmaceuticals, Inc. Officer & Ownership Information

State of Incorporation:

Delaware

Corporate Address:

Eton Pharmaceuticals, Inc.
21925 W. Field Parkway,
Suite 235
Deer Park, IL 60010
Phone: (847) 805-1026

Publicly Traded Company:

Ticker Symbol – (ETON)

Officers:

- Sean Brynjelsen - President; CEO (6% Owner)
  - Address: S. Cook St., Barrington, IL 60010
  - Date of Birth:
  - Contact Number:
  - Not licensed as a pharmacist
- Wilson Troutman - Secretary and Treasurer; CFO (0% Owner)
  - Address: E. Adams St., Lombard, IL 60148
  - Date of Birth:
  - Contact Number:
  - Not licensed as a pharmacist
- David Krempa - Asst. Secretary and Asst. Treasurer; VP of Business Development (0% Owner)
  - Address: Alderman Ave., Prospect Heights, IL 60070
  - Date of Birth
  - Contact Number:
  - Not licensed as a pharmacist

Majority Owner:

Imprimis Pharmaceuticals, Inc. (19% Owner)
12264 El Camino Real #350
San Diego, CA 92130

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
004.004606

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES:
12/31/2020

LICENSED WHOLESALE DRUG DISTRIBUTOR

ETON PHARMACEUTICALS INC
DANKA RADOSAVLJEVIC
21925 W FIELD PKWY STE 235A
DEER PARK, IL 60010-7208

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

13354318

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 4163184

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Secretary

Cecilia Abundis
Acting Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

Nevada State Board of Pharmacy
431 W. Plumb Lane
Reno, NV 89509

Licensee:	ETON PHARMACEUTICALS INC
License Number:	004.004606
Profession:	LICENSED WHOLESALE DRUG DISTRIBUTOR
Specialty:	OTHER
Date of Issuance:	10/04/2018
Expiration Date:	12/31/2020
License Status:	ACTIVE
License Method:	NON-EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

SEAL
IL DEPT. OF FINANCIAL & PROFESSIONAL REGULATION
DIV. OF PROFESSIONAL REGULATION

11

October 30, 2019
Date

Cecilia Abundis
Acting Director
Division of Professional Regulation

Refer to the Department's Web Site at www.idfpr.com *to verify professional licenses via License Look-Up.*

10-K 1 form10-k.htm

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

[X] **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2018

OR

[ ] **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE TRANSITION PERIOD FROM _____ TO

Commission File Number 001-38738

ETON PHARMACEUTICALS, INC.
(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**37-1858472** **(I.R.S. Employer Identification No.)**
21925 W. Field Parkway, Suite 235 **Deer Park, IL** **(Address of principal executive offices)**	**60010-7208** **(Zip Code)**

Registrant's telephone number, including area code: (847) 787-7361

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, $0.001 par value	The Nasdaq Global Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES [ ] NO [X]

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES [ ] NO [X]

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES [X] NO [ ]

Verified DZ

4GG

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **non-transferable checks 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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH_____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☒ Publicly Traded Corporation – Pages 1,2,3,4
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Rigel Pharmaceuticals Inc

Physical Address: 1180 Veterans Blvd.

City: South San Francisco State: CA Zip Code: 94080

Telephone Number: 800-983-1329 Fax Number: 650-624-1279

Toll Free Number: 800-983-1329

E-mail: cohms@rigel.com Website: www.rigel.com

Facility Manager: Christopher Ohms - Director, Supply Chain

Professional qualifications and experience of facility manager: Please find attached resume listing all relevant qualifications and facility management experience.

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership

Is your company VAWD certified by NABP? Yes ☐ No ☒
(If yes, provide a copy of the certificate)
Rigel is not, but our contracted 3PL company is VAWD certified. (see attached)

Licensed as Manufacturer by the FDA? Yes ☒ No ☐
(If yes, provide a copy of your FDA registration)
Rigel is a Virtual MFG - Labeler code - 71332

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 ☒

List the top 4 suppliers your company has been associated with regards to pharmaceutical products that were sold, dispensed or distributed with the last year.

Name: Contracted 3PL: McKesson Specialty Care Dist. Corp.
Address: 4100 Questway, Memphis, TN 38115

Name: Contracted MFG: Patheon Inc.
Address: 111 Consumers Drive, Whitby, Ontario L1N 5Z5 Canada

Name: Contracted MFG: Patheon Inc.
Address: 2100 Syntex Court, Mississauga, Ontario L1N 7K9 Canada

Name: _____
Address: _____

A licensee is not required to have a Nevada State Business License, however, if you do, please provide the number: _____

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 ☒

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

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

CHRISTOPHER M OHMS
Print Name of Authorized Person

20 NOV 2019
Date

Board Use Only	Date Processed:	Amount: 500.00

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: N/A

Corporation Name: Rigel Pharmaceuticals Inc

Mailing Address: 1180 Veterans Blvd.

City: South San Francisco State: CA Zip: 94080

Telephone: 800-983-1329 Fax: 650-624-1279

Contact Person: Christopher Ohms

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: 6/14/1996

Registration number issued: 0-29889

Stock Exchange: RIGL - NASDAQ

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

Include with the application for a 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.

8-K 1 a19-23662_18k.htm 8-K

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 OR 15(d) of The Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): **November 20, 2019**

RIGEL PHARMACEUTICALS, INC.

(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of incorporation)

0-29889	**94-3248524**
(Commission File No.)	(IRS Employer Identification No.)

1180 Veterans Boulevard
South San Francisco, CA
(Address of principal executive offices)

94080
(Zip Code)

Registrant's telephone number, including area code: **(650) 624-1100**

Not Applicable
(Former name or former address, if changed since last report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions (see General Instruction A.2. below):

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Verified

Applicant:

Rigel Pharmaceuticals, Inc.
1180 Veterans Blvd.
South San Francisco, CA 94080
www.rigel.com
Phone: 800-983-1329
Fax: 650-624-1279
EIN: 94-3248524
Hours of operation: 9 am to 5 pm M-F

Delaware C Corporation established 6/14/1996

Corporate Officers: (see chart attached)

Designated Representative:

Christopher Owens
Faroaks Court
San Mateo, CA 94403

cohms@rigel.com
SSN: DOB:

Method of Distribution: Third Party Logistics Provider

McKesson Specialty Care Dist. Corp.
4100 Questway
Memphis, TN 38115 00005456

RxCrossroads 3PL LLC
1001 Cheri Way
Fairdale, KY 40118 M04285

RxCrossroads 3PL LLC
5101 Jeff Commerce Drive
Louisville, KY 40219 TPL00304

Contracted CMO:

Patheon Inc.
111 Consumers Drive
Whitby, Ontario L1N 5Z5 Canada FDA: 3000264888

Patheon Inc.
2100 Syntex Court

Mississauga, Ontario L1N 7K9 Canada FDA: 3000264888

Nature of Business:
Rigel Pharmaceuticals, Inc. is a Virtual Manufacturer of it's own label, FDA approved product, Tavalisse. Their product is manufactured by contract with Patheon in Ontario, Canada and shipped directly to a contracted 3PL company for storage and distribution. Rigel does not ever physically manufacture, store or distribute at their facility in South San Francisco, California. Rigel does not have a license in our home state because California does not currently license virtual manufacturers as per letter attached

FDA Labeler Code: 71332

List of Products to be manufactured:

71332-002-01	Tavalisse 150mg/1 tablet
71332-001-01	Tavalisse 100mg/1 tablet

National Drug Code Directory

SHARE (HTTPS://WWW.FACEBOOK.COM/SHARER/SHARER.PHP?U=HTTPS://WWW.ACCESSDATA.FDA.GOV/SCRIPTS/CDER/NDC/DSP_SEARCHRESULT.CFM)
TWEET (HTTPS://TWITTER.COM/INTENT/TWEET/?TEXT=NATIONAL DRUG CODE DIRECTORY&URL=HTTPS://WWW.ACCESSDATA.FDA.GOV/SCRIPTS/CDER/NDC/DSP_SEARCHRESULT.CFM)
LINKEDIN (HTTPS://WWW.LINKEDIN.COM/SHAREARTICLE?MINI=TRUE&URL=HTTPS://WWW.ACCESSDATA.FDA.GOV/SCRIPTS/CDER/NDC/DSP_SEARCHRESULT.CFM&TITLE=NATIONAL DRUG CODE DIRECTORY&SOURCE=FDA)
PIN IT (HTTPS://WWW.PINTEREST.COM/PIN/CREATE/BUTTON/?URL=HTTPS://WWW.ACCESSDATA.FDA.GOV/SCRIPTS/CDER/NDC/DSP_SEARCHRESULT.CFM&DESCRIPTION=NATIONAL DRUG CODE DIRECTORY)
EMAIL (MAILTO:?SUBJECT=NATIONAL DRUG CODE DIRECTORY&BODY=HTTPS://WWW.ACCESSDATA.FDA.GOV/SCRIPTS/CDER/NDC/DSP_SEARCHRESULT.CFM) PRINT

Current through December 16, 2019

You have searched Finished drug products

Search Results *71332*

Back to Search Page () | Search Again ()

CSV Excel

Display 50 records per page

Search for text in the table:

Proprietary Name	NDC Package Code	Strength	Dosage Form	Route	Appl. No.	Labeler Name	Product NDC	Nonproprietary Name	Substance Name	Product Type Name	Start Marketing Date	End Marketing Date	M. Ci
TAVALISSE	71332-002-01	150 mg/1	TABLET	ORAL	NDA209299	Rigel Pharmaceuticals, Inc	71332-002	FOSTAMATINIB	FOSTAMATINIB	HUMAN PRESCRIPTION DRUG	05/09/2018	N/A	ND/
TAVALISSE	71332-001-01	100 mg/1	TABLET	ORAL	NDA209299	Rigel Pharmaceutcals, Inc	71332-001	FOSTAMATINIB	FOSTAMATINIB	HUMAN PRESCRIPTION DRUG	05/09/2018	N/A	ND/

Showing 1 to 2 of 2 entries

Previous 1 Next

Background Information (https://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm)

Drug questions email **DRUGINFO@FDA.HHS.GOV (mailto:DRUGINFO@FDA.HHS.Gov)**

See also **Drug Registration and Listing Instructions (https://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/DrugRegistrationandListing/ucm078801.htm)**
National Drug Code Directory Data Files (https://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm)

U S Department of Health and Human Services
Public Health Service
Food and Drug Administration
Center for Drug Evaluation and Research
Division of Data Management and Services

Verified DZ

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR.
Governor

March 6, 2017

CERTIFIED MAIL

Raul Rodriguez, President and CEO
Rigel Pharmaceuticals, Inc.
1180 Veterans Boulevard
South San Francisco, CA 94080

RE: **Letter of Exemption - California Drug Manufacturing Licensure**

Dear Mr. Rodriguez:

On November 21, 2016, the California Department of Public Health (CPDH) Food & Drug Branch received a new Drug Manufacturing License application for the facility located at the address listed above. The application packet represents your firm to be a "virtual manufacturer" and asserts that your firm has not been engaged in manufacturing as defined in state law (California Health & Safety Code (H&SC) Section 109970).

On February 7, 2017, the above listed facility was inspected by a CDPH Investigator whose findings support an exemption from licensure at this time. **Therefore, *Rigel Pharmaceuticals, Inc.* located at the facility identified above, is hereby notified that CDPH is denying the new Drug Manufacturing License application received November 21, 2016, without prejudice, based on representations and observations made indicating that California licensing requirements do not apply at this time.**

If manufacturing operations are planned for this facility and you wish to pursue a California Drug Manufacturing License in the future, you will need to submit a new application and fee. A new Drug Manufacturing License application (EH52) may be obtained by contacting the CDPH Drug Licensing Desk, or by downloading from the following website:

http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph52N.pdf

Be reminded that pursuant to H&SC Section 111615, it is illegal to manufacture drugs in CA without a license issued by CDPH. Should it be determined that **Rigel Pharmaceuticals, Inc.** is manufacturing drug products at a California-based facility without a valid license, CDPH may initiate further action including, but not limited to, embargo of violative drugs, assessment of administrative fines, and/or civil or criminal prosecution. It is your responsibility to ensure that all products manufactured by your firm comply with California law.

This correspondence may serve as official notice that your firm is exempt from the need for a California Drug Manufacturing License at this time. (Note: This notice does not relieve any

obligations or requirements specified in California law relative to the scope and practice of Pharmacy and enforced by the California Department of Consumer Affairs Board of Pharmacy.)

If you have any questions or are in need of clarification, please feel free to contact me at (916) 650-6619, or Supervising Investigator June Han at (916) 928-2228.

Sincerely,

Daniel Seid, Chief
Drug Safety Unit
CDPH Food & Drug Branch

cc: June-Mei Han
Supervising Investigator

CDPH Drug Manufacturing License Desk

// firm file

US Food & Drug Administration
San Francisco District Office
1431 Harbor Bay Parkway
Alameda, CA 94502-7070

Fairoaks Court
San Mateo, CA 94403

CHRISTOPHER OHMS

HIGHLIGHTS

- Leader of complex pharmaceutical and biopharmaceutical clinical/commercial supply chain activities.
- Experienced operations manager.
- Manager of pharmaceutical projects, programs, and portfolios from research through commercialization.

EXPERIENCE

Rigel Pharmaceuticals — **South San Francisco, CA**
Director, Supply Chain — *June 2019 - Present*

- Develop manufacturing schedules and inventory plans to support current clinical and commercial requirements. Drive the execution of the plans to assure supplies are available to our end-users.
- Anticipate and plan for on-going material needs to minimize reactive responses for supplies needed by our end-users.
- Develop tools for tracking inventory, cycle times, returns, documentation requirements etc.
- Assure that excipients, raw materials, consumables and supplies are qualified, ordered and available to support manufacturing.
- Develop dashboards and reports to provide visibility into status of supplies throughout the supply chain.
- Responsible for developing and executing project plans and schedules that represent the appropriate level of detail and task independency and have accurate resource planning estimates to support development team objectives.
- Develop manufacturing schedules and inventory plans to support current clinical and commercial requirements. Drive the execution of the plans to assure supplies are available to our end-users.
- Anticipate and plan for on-going material needs to minimize reactive responses for supplies needed by our end-users.
- Develop tools for tracking inventory, cycle times, returns, documentation requirements etc.
- Assure that excipients, raw materials, consumables and supplies are qualified, ordered and available to support manufacturing.
- Develop dashboards and reports to provide visibility into status of supplies throughout the supply chain.
- Responsible for developing and executing project plans and schedules that represent the appropriate level of detail and task independency and have accurate resource planning estimates to support development team objectives.

Coherus Biosciences — **Redwood City, CA**
Senior Director, Supply Chain — *January 2019- May 2019*

- Enhanced and optimized the inventory/production planning tool (Excel-based) to include key elements from Agreements, Demand/Sales Plan, and CMO-related expenses to analyze future months-on-hand (MOH) positions.
- Facilitated Executive Sales & Operations Planning (S&OP) process.
- Defined and developed the CMC Lifecycle Management (LCM) process; balancing risks to support commercial product lifecycle activities.
- Developed systems and processes central to supply chain management; adapt systems to support the corporate goals.
- Led cross-functional discussions central to supporting supply chain.
- Created Supply Chain Responsibility Assignment Matrix (RACI) in collaboration with cross-functional teams.

Pain Therapeutics **San Mateo, CA**
Director, Strategic Sourcing and Operations Planning *2001 – 2010*

- CMC lead between King Pharmaceuticals and Pain Therapeutics for scale-up and initial NDA of Remoxy™ - $400M partnership; collaborated on the authorship of CMC section.
- Designed/developed web-accessible MS Access databases for financial/budget tracking, central file organization (designed around sections of NDA), and virtual inventory management control.
- Managed global CxOs from API, manufacturing, and packaging/labeling of clinical trial materials (CTM) to support required studies (human and animal) leading to an NDA for an abuse-resistant opioid (CII) painkiller (Remoxy™).
- Negotiated with material suppliers and transport service organizations toward a total annual savings of ~$250K to Pain Therapeutics, Inc.
- Negotiated and prepared proposals and work plans with outsourcing production contractors to save
- Pain Therapeutics, Inc. ~$500K in external expenses.

PATENTS AND INVENTIONS

- Provisional Patent – *Dental Food-Trap Removing Floss*
- Patent – *Closure System for an Active Agent Delivery Device* (Co-authored Patent No. 6595951)
- Patent – *Flow Controller Configurations for an Active Agent Delivery Device* (Co-authored Patent No. 5985324, 6224908, 6103265,& EP098476 A1)
- Patent – *Closure System for an Active Agent Delivery Device* (Co-authored Patent No. 6096003)
- Patent – *Directional Drug Delivery and Method of Use Innovative Cardiac Stent Drug Delivery Device* (Primary inventor; inventor rights assigned to ALZA Corporation, Patent No. 6071305)

EDUCATION

Notre Dame de Namur University (College of Notre Dame) **Belmont, CA**
Master of Arts in English (Technical Writing/Literature)
Notre Dame de Namur University (College of Notre Dame) **Belmont, CA**
Bachelor of Science in Biology (Pre-Med Biology with Chemistry)

CERTIFICATES, LICENCES, AND INTERESTS

- Advanced Clinical Anatomy Workshops (n=4), Stanford School of Medicine
- CPR/AED certified, blood-borne pathogen training, OSHA training, Lean/Six Sigma (Black Belt)
- Writing [LinkedIn]
  - "Lifestyle Changes From A Diagnosis of Adult Onset Multiple Sclerosis"
  - "Packaging Summit: Initiating Site-Wide Continuous Improvement in Packaging/Labeling Operations"

RIGEL

ATTACHMENT # 1

Rigel Pharmaceuticals, Inc.

Company Corporate Officers

Name	Position/Title	Address	Phone #	SS # (last 4 digits)	DOB	% Owned
Raul R. Rodriguez	President and CEO	21st Street San Francisco, CA 94114				1.87%
Anne-Marie Duliege, M.D., M.S.	Executive VP and Chief Medical Officer	Seale Avenue Palo Alto, CA 94303				0%
Eldon C. Mayer III	Executive VP and Chief Commercial Officer	Shady Lane Los Gatos, CA 95032	-			0%
Dolly Vance	Executive VP, Corporate Affairs and General Counsel	Bradford Street San Francisco, CA 94110				1.09%
Esteban Masuda, Ph.D.	Senior VP, Research	Oakhurst Place Menlo Park, CA 94025	-			0%
Joseph Lasaga	VP, Business Development and Alliance Management	Warwick St. Redwood City, CA, 94062				0%
Nelson D. Cabatuan	Interim CFO	Sonas Dr Hayward, CA 94542				0%

Business Address for all officers:

1180 Veterans Blvd.
South San Francisco, CA 94080

800-983-1329

Delaware

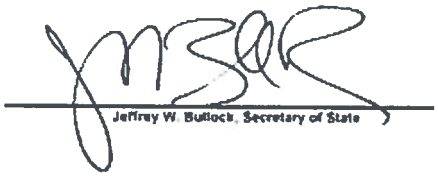
The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "RIGEL PHARMACEUTICALS, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-SIXTH DAY OF NOVEMBER, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "RIGEL PHARMACEUTICALS, INC." WAS INCORPORATED ON THE FOURTEENTH DAY OF JUNE, A.D. 1996.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.





2626346 8300

SR# 20198321023

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 204092348

Date: 11-26-19

4HH

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **non-transferable checks 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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH_____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4
☑ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☐ Partnership - Pages 1,2,3,7
☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Performance Health Supply, Inc.

Physical Address: 9040 Orly Road, Suite 200

City: Indianapolis State: IN Zip Code: 46241

Telephone Number: (630) 393-6000 Fax Number: (630) 393-6002

Toll Free Number: 800-556-3326

E-mail: jeff.lea@performancehealth.com Website: www.performancehealth.com

Facility Manager: Ron Dinderski

Professional qualifications and experience of facility manager: Refer to the attached resume

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☑ Hospitals ☑ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☑ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☑ Other: Over-the-Counter
☐ Hypodermic Devices
☐ Veterinary Legend Drugs

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership

Is your company VAWD certified by NABP? Yes ☐ No ☑
(If yes, provide a copy of the certificate)

Licensed as Manufacturer by the FDA? Yes ☐ No ☑
(If yes, provide a copy of your FDA registration)

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 ☑

List the top 4 suppliers your company has been associated with regards to pharmaceutical products that were sold, dispensed or distributed with the last year.

Name: SHENZHEN DONGDIXIN TECHNOLOGY CO, LTD.
Address: No. 3 Building Xilibaimang Xusheng Industrial Estate, Nanshan, Shenzhen Shenzhen Guangdong, CHINA 518108

Name: TENS PLUS INDUSTRIAL CO
Address: Hing Yip St. Kwun Tong, Kowloon HONG KONG, CHINA NONE

Name: SEIRIN CORPORATION
Address: 1007-1 Sodeshi-Cho, Shimizu-Ku, Shizuoka, 22, JP, 424-0037

Name: Shanghai Kangnian Medical Device CO.LTD.
Address: Qingpu District Shanghai Shanghai, CHINA 201707

A licensee is not required to have a Nevada State Business License, however, if you do, please provide the number: N/A

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 ☑

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

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

Paul Hanneman, VP RA & QA
Print Name of Authorized Person

9-12-2019
Date

Board Use Only	Date Processed:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Minnesota

Parent Company if any: Performance Health Holdings, Inc.

Mailing Address: 9040 Orly Road, Suite 200

City: Indianapolis State: IN Zip: 46241

Telephone: (630) 393-6000 Fax: (630) 393-6002

Contact Person: Paul Hanneman

For any corporation non-publicly traded, disclose the following:

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

a) Lani Holdings, Warrenville, IL
Name Business Address

b) Madison Dearborn Partners, Warrenville, IL
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. Refer to the Lani Holdings Stock Certificates

3) What was the price paid per share? _____

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

Include with the application for a non-publicly traded corporation

List of officers and directors

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.

PERFORMANCE HEALTH | Formerly Patterson Medical

PERFORMANCE HEALTH SUPPLY, INC.
FEIN: 20-4590834
Incorporated in the State of MN on 3/29/2006

Performance Health Holdings, Inc – Parent Company
Address: 28100 Torch Parkway, Suite 700, Warrenville, IL 60555
Ownership: 100%

Paul Hanneman – Regulatory Officer
Business Address: 28100 Torch Parkway, Suite 700, Warrenville, IL 60555
Business Phone: (630) 393-6000
Ownership: 0%

Sean Muniz- Chief Supply Chain Officer
Business Address: 28100 Torch Parkway, Suite 700, Warrenville, IL 60555
Business Phone: (630) 393-6000
Ownership: 0%

PERFORMANCE HEALTH | Formerly Patterson Medical

Performance Health Supply, Inc. - Business Description

Performance Health Supply, Inc. Indiana facility is a distributor of products to the rehabilitation and sports medicine markets. The company's products are sold to leading healthcare facilities and practitioners such as physical therapists, athletic trainers, and chiropractors. The distribution center located in Indiana provides prescription and nonprescription medical devices and other consumable products. The prescription devices do not contact Rx Drugs.

Facility Contact Personnel

Performance Health Supply, Inc.
9040 Orly Rd, Suite 200
Indianapolis, IN 46241
Jeff Lea (Director of Distribution)
Phone: 574-532-9184
Email Address: jeff.lea@performancehealth.com

Performance Health Supply, Inc.
9040 Orly Rd, Suite 200
Indianapolis, IN 46241
Ronald P Dinderski (Manager Distribution Operations)
Phone: 716-310-6986
Email Address: ron.dinderski@performancehealth.com

PERFORMANCE HEALTH | Formerly Patterson Medical

LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER OF CONTACT PERSONNEL FOR THE FACILITY:

Performance Health Supply, Inc.
ADDRESS: 9040 Orly Road, Suite 200, Indianapolis, IN 46241
CONTACT PERSON: Jeff Lea
TELEPHONE: (574) 532-9184

Performance Health Supply, Inc.
ADDRESS: 9040 Orly Road, Suite 200, Indianapolis, IN 46241
CONTACT PERSON: Ronald P Dinderski
TELEPHONE: (716) 310-6986

PERFORMANCE HEALTH | Formerly Patterson Medical

Performance Health Supply, Inc. - Business Description

Performance Health Supply, Inc. Indiana facility is solely a distribution facility that provides prescription and nonprescription medical devices, and OTC drugs and cosmetics primarily to rehabilitation and physical/occupational therapy markets. The Indiana Performance Health Supply, Inc. site does not perform physical manufacturing or sales activity. There are no prescription drugs or list 1 DEA chemicals either stored at or distributed from this site.

From: Group 04
To: Walker, Janine
Subject: RE: Indiana Board of Pharmacy _ Distribution of Medical Devices
Date: Tuesday, July 02, 2019 7:49:33 AM
Attachments: image002.png

As long as the non-prescription medical devices do not include drugs then you do not need a license.

Jody Edens,
Assistant Board Director
Indiana Professional Licensing Agency
Indiana Board of Pharmacy
Speech Language Pathology and Audiology Board
Hearing Aid Dealer Committee
402 West Washington Street, Room W072
Indianapolis, IN 46204
(317) 234-2067
(317) 233-4236 fax
website: www.pla.in.gov



"The Indiana Board of Pharmacy, Speech Language Pathology Board and the Committee of Hearing Aid Examiners and Professional Licensing Agency ("PLA") staff cannot and do not provide legal advice. PLA staff provide assistance to the public by providing reference to the Indiana statute and Rules; however, any such assistance provided by PLA staff shall not be construed as legal advice for any particular situation, nor shall any such assistance be construed to communicate all applicable laws and regulations governing any particular situation or occupation. Please consult an attorney of your own choosing regarding any legal questions related to state or federal laws or regulations, including the interpretation and application of the laws and regulations governing the board."

From: Walker, Janine [mailto:Janine.Walker@iqvia.com]
Sent: Monday, July 01, 2019 2:52 PM
To: Group 04 <pla4@pla.IN.gov>
Subject: Indiana Board of Pharmacy _ Distribution of Medical Devices

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Good Afternoon,

I am inquiring to see if your state licenses an in-state distributor of non-Prescription medical devices?

I look forward to your response.

Thank you for your time and assistance.

Kind Regards,

Janine Walker
Senior Licensing Analyst
U.S. Compliance Solutions (formerly BuzzeoPDMA)

IMS Health & Quintiles are now IQVIA™

Learn more about IQVIA™

1025 Boulders Parkway, Suite 301
Richmond, VA 23225
USA
Janine.walker@iqvia.com
Please note new number: O: +1- 804-230-5048 |F: +1-804-267-1747

IMPORTANT - PLEASE READ: This electronic message, including its attachments, is CONFIDENTIAL and may contain PROPRIETARY or LEGALLY PRIVILEGED or PROTECTED information and is intended for the authorized recipient of the sender. If you are not the intended recipient, you are hereby notified that any use, disclosure, copying, or distribution of this message or any of the information included in it is unauthorized and strictly prohibited. If you have received this message in error, please immediately notify the sender by reply e-mail and permanently delete this message and its attachments, along with any copies thereof, from all locations received (e.g., computer, mobile device, etc.). To the extent permitted by law, we may monitor electronic communications for the purposes of ensuring compliance with our legal and regulatory obligations and internal policies. We may also collect email traffic headers for analyzing patterns of network traffic and managing client relationships. For further information see: https://www.iqvia.com/about-us/privacy/privacy-policy. Thank you.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 8/28/2018

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: RISK MANAGEMENT	
NFP Property & Casualty Services Inc. 45 Executive Drive Plainview NY 11803-9001	PHONE (A/C, No, Ext): 516-327-2700	FAX (A/C, No): 516-327-2800
	E-MAIL ADDRESS: RiskCerts@nfp.com	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Federal Insurance Company	20281
INSURER B : Great Northern Insurance Company	20303
INSURER C : Continental Casualty Company	20443
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Lanai Holdings I LLC
Performance Health Supply, Inc.
28100 Torch Parkway, Suite 700
Warrenville IL 60555-3938

COVERAGES **CERTIFICATE NUMBER:** 1369786502 **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	
B	X COMMERCIAL GENERAL LIABILITY			36028749	8/28/2018	8/28/2019	EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	X EXCL-SCHEDULED						MED EXP (Any one person)	$ 10,000
	[ ] DISEASES						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	[ ] POLICY [ ] PRO-JECT [X] LOC						PRODUCTS - COMP/OP AGG	$ EXCLUDED
	[ ] OTHER:							$
A	AUTOMOBILE LIABILITY			73590418	8/28/2018	8/28/2019	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A C	X UMBRELLA LIAB [X] OCCUR			79896067	8/28/2018	8/28/2019	EACH OCCURRENCE	$ 25,000,000
	X EXCESS LIAB [ ] CLAIMS-MADE			6043178097	8/28/2018	8/28/2019	AGGREGATE	$ 25,000,000
	[ ] DED [ ] RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			71750454	8/28/2018	8/28/2019	X PER STATUTE [ ] OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
A	Products/Completed Operations Claims Made Form Retro Date 8/28/15			99496897	8/28/2018	8/28/2019	Each Occurrence/Aggre BI/PD Ded. (Ea Event) BI/PD Ded. (Aggregat)	$10,000,000 $150,000 $750,000

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

EVIDENCE OF INSURANCE

CERTIFICATE HOLDER

MEDCO SUPPLY COMPANY
25 Northpointe Pkwy
Suite 25
Amherst NY 14228

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

© 1988-2015 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

Office of the Minnesota Secretary of State
Certificate of Good Standing

I, Steve Simon, Secretary of State of Minnesota, do certify that: The business entity listed below was filed pursuant to the Minnesota Chapter listed below with the Office of the Secretary of State on the date listed below and that this business entity is registered to do business and is in good standing at the time this certificate is issued.

Name:	Performance Health Supply, Inc.
Date Filed:	03/29/2006
File Number:	1780554-2
Minnesota Statutes, Chapter:	302A
Home Jurisdiction:	Minnesota
This certificate has been issued on:	07/23/2019

Steve Simon
Secretary of State
State of Minnesota

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane
Reno, NV 89509
(775) 850-1440
Fax: (775) 850-1444

PHARMACEUTICAL WHOLESALER SURETY BOND

Bond No. 76176522

Application/License No. _____

Performance Health Supply, Inc. (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is 9040 Orly Road, Suite 200, Indianapolis, IN 46241 (Address of Applicant/Principal), as PRINCIPAL, and The Guarantee Company of North America, USA (Surety Company), a corporation organized under the laws of the state of Michigan (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is One Town Square, Suite 1470, Southfield, Michigan 48076 (Address of Surety) as SURETY, are held and firmly bound unto the State of Nevada and to the Nevada State Board of Pharmacy for the penal sum of ONE HUNDRED THOUSAND DOLLARS ($100,000.00), for which payment we bind ourselves, our heirs, executors, administrators, successors and assigns jointly and severally, by these presents. This bond term shall become effective on August 22, 2019 (Effective Date).

WHEREAS, the provisions of Nevada Revised Statutes (NRS) 639.515 require that the Applicant/Principal file or have on file with the Nevada State Board of Pharmacy (Board) a bond in the sum of $100,000.00 payable to the Nevada State Board of Pharmacy and this bond is executed and tendered in accordance therewith. This bond secures payment of any administrative fines imposed by the Board pursuant to NRS 639.255 and any costs incurred by the Board regarding the license of Applicant/Principal that are impose pursuant to NRS 622.400 or 622.410 which the Applicant/Principal fails to pay.

THIS BOND is subject to the following conditions:

(1) This bond shall be deemed continuous in form and shall remain in full force and effect and shall run concurrently with the license period for which the license is granted and each and every succeeding license period or periods for which said Applicant/Principal

may be licensed, after which liability hereunder shall cease except as to any liability or indebtedness therefore incurred or accrued hereunder.

(2) This bond is executed by the Applicant/Principal and the Surety to comply with the provisions of NRS 639.515 and said bond shall be subject to all of the terms and provisions thereof.

(3) The Surety, its successors and assigns, are jointly and severally liable on the obligations of the bond.

(4) The limitations of the liability of the Surety and the conditions of the bond are set forth in NRS 639.515. Any claim by the Board may be made directly to the Surety and need not be preceded by the filing of any action in a proper court. Payment of any such claim shall be payable to the Nevada State Board of Pharmacy.

(5) The aggregate liability of the Surety hereunder on all claims whatsoever shall not exceed the penal sum of this bond in any event.

(6) This bond may not be cancelled by the Surety without first giving the Board written notice at least thirty days in advance of any intent to cancel the bond.

(7) The Applicant/Principal and Surety may be served with notices, papers and other documents at the addresses given above.

I certify or declare under penalty of perjury, under the laws of the State of Nevada, that I have executed the foregoing bond on behalf of the Surety under an unrevoked power of attorney.

In witness whereof, each party to this bond has caused it to be executed on this **22nd** day of **August**, 20**19**.

Performance Health Supply, Inc.
APPLICANT/PRINCIPAL

Mark A. [signature]
Authorized Representative

SIGNED and SEALED in the presence of:

[signature]
Witness

[signature]
Witness

The Guarantee Company of North America, USA
SURETY COMPANY

[signature]
Surety Company's Representative

Matthew Wilkoff, Attorney-in-fact
print name

SIGNED and SEALED in the presence of:

[signature]
Witness

[signature]
Witness

Countersigned by:

N/A
Nevada Resident Agent

Individual Acknowledgment

State of _____

County of _____

On the _____ day of _____, 20____, before me personally appeared _____

_____

to me known and known to me to be the person described in and who executed the foregoing instrument and _____he_____ thereupon acknowledged to me that _____he_____ executed the same.

_____ Notary Public

Partnership/L.L.C. Acknowledgment

State of _____

County of _____

On the _____ day of _____, 20____, before me personally appeared _____

_____

to me known and known to me to be one of the firm of _____

described in and who executed the foregoing instrument and _____he_____ thereupon acknowledged to me that _____he_____ executed the same as and for the act and deed of said firm.

_____ Notary Public

Corporate Acknowledgment

JUDITH L DIAMOND
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 6, 2020

State of Illinois

County of DuPage

On the 23rd day of August, 2019, before me personally appeared _____

Mark Fortkamp

to me known, who being by me duly sworn, did depose and say that _____he_____ is the _____

Treasurer of the Performance Health Supply, Inc

the corporation described in and which executed the foregoing instrument; that _____he_____ knows the seal of said corporation; that the seal affixed to said instrument is such corporate seal; that it was so affixed by order of the board of directors of said corporation; and that _____he_____ signed his/her name thereto by like order.

Judith L Diamond Notary Public

ACKNOWLEDGEMENT OF SURETY COMPANY

State of New York
County of Nassau } ss.

On August 22, 2019 before me personally came Matthew Wilkoff to me known, who, being by me duly sworn, did depose and say; that he resides in Mineola, NY; that he is the Attorney-In-Fact of The Guarantee Company of North America USA the corporation described in which executed the above instrument; that he knows the seal of said corporation; that the seal affixed to said instrument is such corporate seal; that is was so affixed by the Board of Directors of said corporation; and that he signed his name thereto by like order.

SUSAN KINNEAR
NOTARY PUBLIC, State of New York
No. 01KI6373947
Certificate Filed in Suffolk County
Commission Expires April 16, 2022

Susan Kinnear
Notary Public

Form M12 (04/91)

411

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 208, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE WHOLESALER 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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH_____

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

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Partnership - Pages 1,2,3,7
☐ Non Publicly Traded Corporation – Pages 1,2,3,5,6
☑ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Pharmsource Animal Health, LLC

Physical Address: 123 Newman Drive Suite A

City: Brunswick, GA State: Zip Code: 31520 Telephone

Number: 912-235-0480 Fax Number: 877-240-5344

Toll Free Number: _____

E-mail: compliance.pharmsourcellc@gmail.com Website: Pharmsourcewholesale.com

Facility Manager: Jeff Herman

Professional qualifications and experience of facility manager: See attached resume.

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers
☑ Other: Veterinarian and vet hospitals

Type of Products to be handled or wholesaled by firm:

☑ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Other: _____
☐ Hypodermic Devices
☑ Veterinary Legend Drugs

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership

Is your company VAWD certified by NABP? Yes ☐ No ☑
(If yes, provide a copy of the certificate)

Licensed as Manufacturer by the FDA? Yes ☐ No ☑
(If yes, provide a copy of your FDA registration)

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 ☑

List the top 4 suppliers your company has been associated with regards to pharmaceutical products that were sold, dispensed or distributed with the last year.

Name: Auromedics Pharma LLC
Address: 279 Princeton Hightstown Rd, East Windsor, NJ 08520

Name: McKesson Corporation
Address: 6555 State Hwy 161 Irving, TX 75039

Name: Top RX
Address: 2950 Brother Boulevard Bartlett, TN 38133

Name: Teva Pharmaceutical Industries Ltd
Address: Petah Tikva, Israel

A licensee is not required to have a Nevada State Business License, however, if you do, please provide the number: _____

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 ☑

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

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

Jeff Herman
Print Name of Authorized Person

7/15/19
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

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

Owner's Name: Jeff Herman

Business Name: Pharmsource Animal Health, LLC

Current Business Address: 123A Newman Drive

City: Brunswick State: GA Zip Code: 31520

Telephone: (912) 235-0480 Fax: (877) 240-5344

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

Include with the application for a sole owner

***If VAWD certified by NABP, fingerprints, list of employees and bond are not required. Please provide a copy of your VAWD certification.

***If you are a FDA registered manufacturer, fingerprints, list of employees and bond are not required. Please provide a copy of your FDA registration.

If your company is not VAWD certified by NABP, or an FDA registered manufacturer you will need to complete the following:

Submit fingerprints – Please refer to Fingerprint Submission Instructions

http://bop.nv.gov/uploadedFiles/bopnvgov/content/Services/newapps/7.1.2019.Fingerprint%20Submission%20Instructions.pdf.

Submit a list containing each employee(s) who handle the drugs on a daily basis.

Copy of a bond in an amount of $100,000.00 made payable to the State of Nevada. A bond or other form of security must be current in order to maintain and keep a Nevada wholesaler registration. Blank surety bond, certificate of deposit, letter of credit or cash deposit are included under the new application tab entitled "Wholesalers Only".

List of all current state licenses

Georgia

- License No: PHWH004627
- Issue Date: 07/05/2019
- Expiration Date: 06/30/2021

STATE OF GEORGIA
Department of Community Health
Georgia State Board of Pharmacy
Wholesaler Pharmacy

License No. PHWH004627 Status: Active

Pharmsource Animal Health LLC
123 Newman Drive Ste A
Brunswick GA 31520

Expires: 6/30/2021
Issued: 7/5/2019

Real-time license verification is available at gadch.mylicense.com/verification

Above is your wall license to practice your profession. A pocket-sized license card is below.

Please make note of the expiration date on your license. It is your responsibility to renew your license before it expires.

Please notify the Board if you have a change of address or otherwise need to update your records.

STATE OF GEORGIA
Department of Community Health
Georgia State Board of Pharmacy
Wholesaler Pharmacy
License No. PHWH004627 - Active

Pharmsource Animal Health LLC
123 Newman Drive Ste A
Brunswick GA 31520

Issued: 7/5/2019
Expires 6/30/2021

Real-time license verification is available at gadch.mylicense.com/verification

Licensee Information

Name: Pharmsource Animal Health LLC

Owner:

Address: 123 Newman Drive Ste A
Brunswick GA 31520

Primary Source License Information

Profession:	Pharmacy	**License No:**	PHWH004627	**License Status:**	Active
License Type:	Wholesaler Pharmacy	**Obtained By Method:**	Application	**License Subtype:**	
Issue Date:	7/5/2019	**Expiration Date:**	6/30/2021	**Last Renewal Date:**	

Discipline Information

- Public Board Orders -

If a public board order exists, it may be listed below.
Public Board Order means that there is a public document concerning the licensee.
The existence of a public Board order does not necessarily mean the licensee is currently under any type of disciplinary action.

Please understand that the absence of a scanned order linked to this record does not necessarily mean that no public actions exist.

No scanned public board order documents exist.

Associated Licenses

No data available

You may close this window to return to your search results

Data current as of: July 29, 2019 9:46:49

This website is to be used as a primary source verification for licenses issued by the Boards of Dentistry and Pharmacy. Paper verifications are available for a fee. Please contact the Boards of Dentistry and Pharmacy at 404-651-8000.

List of employees who handle the drugs on a daily basis

Contact Person: David Scott – VP of Supply Chain

Address: Huntingdon Road, Kannapolis, NC 28081

Telephone number: '

Owner: Jeff Herman - CEO

Address: SW 15 Manor, Davie, Florida 33325

Telephone number:

JEFF HERMAN

Cell

Blair Road
Unit D4
St.Simons Island, Ga. 31522

Email:

Vice President, Inside Sales/Regulatory Affairs

Results-driven management executive with 21 years experience in training, development and project management, including years of call center management in high volume domestic operations. Skilled as an internal consultant in analyzing existing operations and implementing the strategies, processes and technologies to improve productivity and efficiency. Expert in facilitating change in a sales force to support organizational operating and financial objectives. Experience with P&L management, warehouse, regulation, licensing, cross-company strategic project management, human resources, and benchmarking.

Expertise in:

-Customer Relations
-State Licensure
-Team Building
-Productivity/Process Improvement
-Warehouse Operations
-Sales Training
-Motivating Employees
-Strategic Planning

PROFESSIONAL EXPERIENCE

7/1/15 - Current **Pharmsource, LLC. - Brunswick, Georgia**
Vice President, Operations

- Updating and maintaining Standard Operating Procedures manual for state inspection.
- Securing state licensure
- E-Commerce Website Creation
- Opening Call Center in South Florida
- Upgrading and maintaining ERP (SAP Business One)
- Sales Rep recruitment and training
- Oversight of Inventory and Warehouse Operations
- Local, State and Federal Compliance

10/01/07- 5/01/15 **Bellco Generics (AmeriSourceBergen)- Fort Lauderdale, Fl**
Vice President, Business Development

- Manage 54 inside sales reps calling on independent, chain, and LTC pharmacies nationally selling generic, brand, OTC, and injectable pharmaceuticals.
- Cycle Count check of inventory
- Short Dated Inventory Analysis
- Loss Prevention
- Responsible for Morgue inventory
- Creation of Warehouse SOP's
- Regulatory Site Inspection Check List
- Assisted in State License Renewals
- Trained staff on selling generic injectables increasing sales on these s.k.u.'s by $20k per month.
- Developed "Pods" with Pod Leaders which resulted in increased retention and better training for sales reps.
- Created an account sales comparison report monthly for each rep, and consulted with each rep on accounts that had decreased their business with the company from the previous month.
- Trained staff on up selling, Gross Profit configuration, cross selling, and overcoming objections.

2/16/05-8/17/07 **Southwood Pharmaceuticals Inc. - Lake Forest, CA.**
Vice President of Regulatory Affairs

Responsible for recruiting, training, directing & managing 23 sales associates. Establish performance initiatives, goal oriented incentives and strategies to maximize sales growth and achieve company goals and profitability. Developed competitive & market driven sales strategies. Proven ability to develop new business and increased sales. Provided sales field reports on competitive activity, changes in markets, distribution & pricing. Provide continuous tools and education to ensure proficient levels of industry, competitor & product knowledge. Assertive negotiator with a proven track record. Effective speaker, motivator, trainer, and organizer at recruiting fairs, corporate events, and industry shows.

Key Accomplishments

- 2007 - Verified-Accredited Wholesale Distributors (VAWD) Accreditation by National Association of Boards of Pharmacy (NABP)

- 2007 -2011Participation in Northeast largest regional GPO – (IPC) Innovative Purchasing Concepts - worked with National Account Manager and Contracts Administrator to ensure that our internal systems and processes supported our

customers increased demands for services and products at lowest prices possible through partnership with IPC

- 2006 - 2009 Maintained sustainable annualized sales growth averaging 35%
- 2006 - 2009 Managed Premier Purchasing Partners Buying Group - designated as Membership Administrator responsible for Group Purchasing Agreement-Pharmacy Distribution document review, Letter of Participation (LOP), Terms & Conditions, determining Service Grid, Returned Goods policy, admin fees, and data transfer through web based Passport access
- 2006 - 2008 Managed "Drug Guild / McKesson" GPO program designed by VP of Pharmacy services.
- 2006 - 2007 Partnered with National Sales Account Manager in the launching and management of GSPO CO-OP Power program that resulted in new business opportunities and increased revenues from existing customer base.
- 2006 - Introduced "Work at Home" program, driving sales on a National scale
- 2005 - 2008 Recruit, trained, and managed Sales Associates resulting in annualized 100% sales growth within first yr.
- 2005 - 2006 Obtained Distributor Licensure in 48 states
- 2005 - Researched, planned and strategically located property and opened Call Center in Niagara Falls, NY.

5/1999-1/2005 **Expert-Med Inc. – Ormond Beach, Fl.**
Inside Sales Manager

- Promoted to sales manager quickly after my success as an inside sales representative. Managed 25 reps calling on pharmacies and physician offices nationwide.
- Responsible for sales of over 6,000 s.k.u.'s to include generic meds, injectables, vaccines, med/surg supplies, OTC's, and c-2 products.
- My sales team reactivated an average of 30 physician accounts, 25 pharmacy accounts, and launched an average of 5 new generics every month!
- Increased company sales from $630,000/month to $5 million/month. Increased company margin from 11% to 16% after helping implement a new commission structure incentivizing reps to sell at a higher gross profit.
- Developed and facilitated a two week comprehensive training program for new sales reps.
- Created sales promotions to constantly motivate sales reps.
- Direct sales meetings focusing on overcoming objections, role playing, and product knowledge.

- Assign territories and specific sales goals.
- Created customer promotions to generate interest in products. Worked with vendors for promotional money, contests, and buy-ins for customers.
- Created and implemented "Pod Leader" concept to have more ongoing training available to sales reps.
- Worked various trade shows including NCPA, NCPA Multiple Location Conference, NACDS, and ECRM securing new customers and developing existing relationships with current customers.

8/1998-5/1999 **Expert-Med Inc. - Ormond Beach, Fl.**
Inside Sales Representative

- Grew an account base to exceed sales of $180,000/month by my sixth month in the industry. Successfully launched new products to my account base by prebooking them beforehand and following up with service calls after the sale.
- Responsible for collecting each account, and completing an accounts receivable report on each account.

EDUCATION

University of Phoenix - 12/2012, Fort Lauderdale, Fl.
M.B.A.

University of Central Florida- 12/2000 Daytona Beach, Fl.
B.S. Business Administration

Daytona Beach Community College-12/1998 Daytona Beach, Fl.
Associate Degree

ACCOMPLISHMENTS

1/2003 Earned A.M.D.R. certification (Accredited Medical Distributor Representative.)

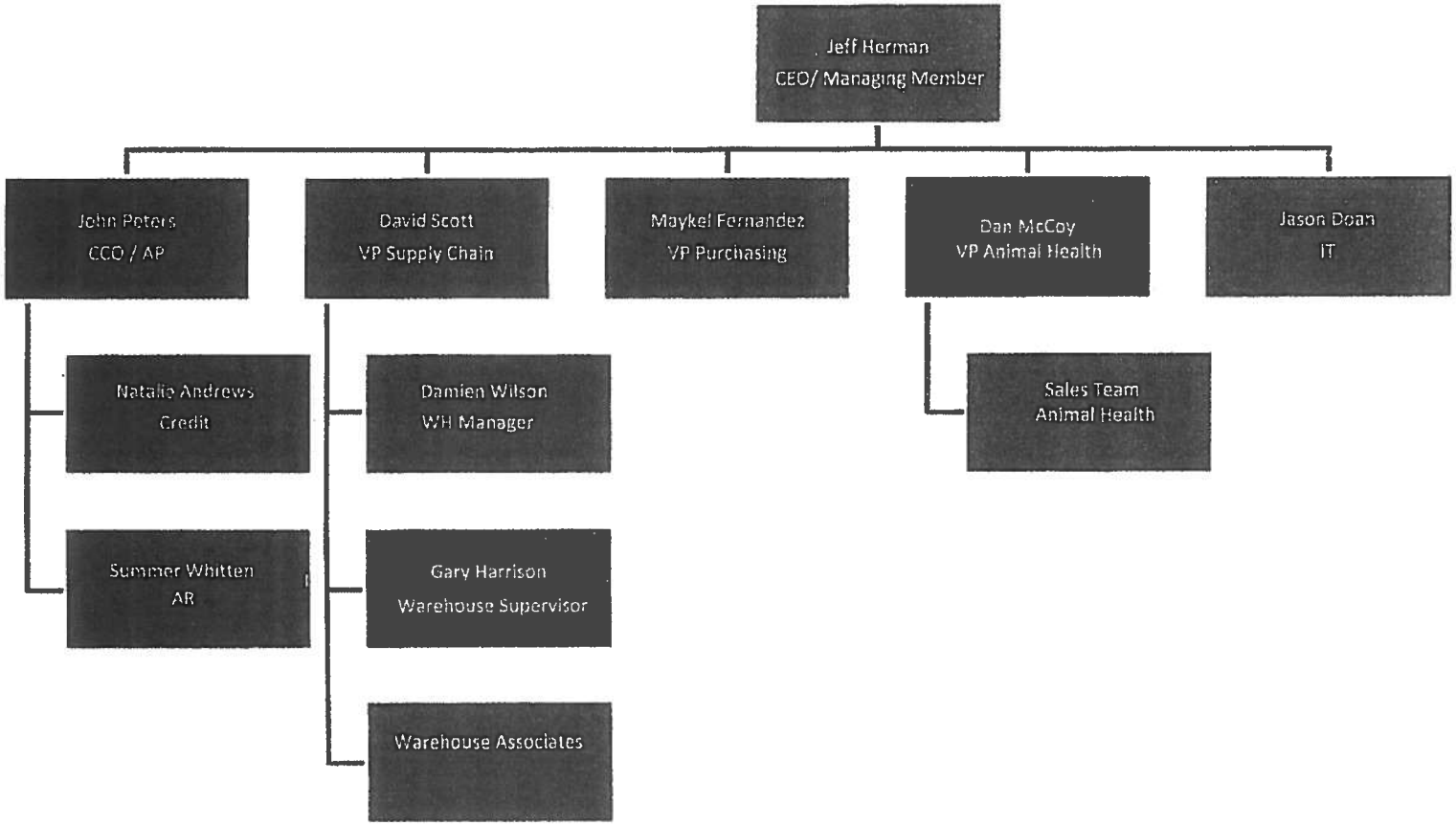
10/2002 Completed Dale Carnegie seminar on "Motivating your employees."

Computer Experience

Hardware: IBM (Compatible) PC, AS400, Mainframe, SUN, IBM RISC 6000, BIZTALK, Exchange Server, Terminal Server, Domain Servers, Navision Server, CiscoPix VPN, Web Server

Operating / Software Sys: XP, Office 2007, UNIX PC Software, Outlook, Word, WordPerfect, Paradox, Excel, Lotus, ACCPAC, Ramba, Platinum, PowerPoint, QuickBooks, Visio, E-CSOS, E-Pedigree, Data-trans EDI, Video-Conferencing, Microsoft Dynamics NAVISION versions 3.6 – 2009R2, M5 VOIP, MYFAX, Microsoft CRM

Pharmsource. LLC 123 Newman Drive, Brunswick, GA 31520



NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane
Reno, NV 89509
(775) 850-1440
Fax: (775) 850-1444

PHARMACEUTICAL WHOLESALER SURETY BOND

Bond No. 41417815

Application/License No. _____

Pharmsource Animal Health, LLC (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is 123 Newman Drive, Brunswick, GA 31520 (Address of Applicant/Principal), as PRINCIPAL, and PLATTE RIVER INSURANCE COMPANY (Surety Company), a corporation organized under the laws of the state of NEBRASKA (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is 2121 N CALIFORNIA BLVD #300, WALNUT CREEK, CA 94596 (Address of Surety) as SURETY, are held and firmly bound unto the State of Nevada and to the Nevada State Board of Pharmacy for the penal sum of ONE HUNDRED THOUSAND DOLLARS ($100,000.00), for which payment we bind ourselves, our heirs, executors, administrators, successors and assigns jointly and severally, by these presents. This bond term shall become effective on September 1, 2019 (Effective Date).

WHEREAS, the provisions of Nevada Revised Statutes (NRS) 639.515 require that the Applicant/Principal file or have on file with the Nevada State Board of Pharmacy (Board) a bond in the sum of $100,000.00 payable to the Nevada State Board of Pharmacy and this bond is executed and tendered in accordance therewith. This bond secures payment of any administrative fines imposed by the Board pursuant to NRS 639.255 and any costs incurred by the Board regarding the license of Applicant/Principal that are impose pursuant to NRS 622.400 or 622.410 which the Applicant/Principal fails to pay.

THIS BOND is subject to the following conditions:

(1) This bond shall be deemed continuous in form and shall remain in full force and effect and shall run concurrently with the license period for which the license is granted and each and every succeeding license period or periods for which said Applicant/Principal may be licensed, after which liability hereunder shall cease except as to any liability or indebtedness therefore incurred or accrued hereunder.
(2) This bond is executed by the Applicant/Principal and the Surety to comply with the provisions of NRS 639.515 and said bond shall be subject to all of the terms and provisions thereof.
(3) The Surety, its successors and assigns, are jointly and severally liable on the obligations of the bond.
(4) The limitations of the liability of the Surety and the conditions of the bond are set forth in NRS 639.515. Any claim by the Board may be made directly to the Surety and need not be preceded by the filing of any action in a proper court. Payment of any such claim shall be payable to the Nevada State Board of Pharmacy.
(5) The aggregate liability of the Surety hereunder on all claims whatsoever shall not exceed the penal sum of this bond in any event.
(6) This bond may not be cancelled by the Surety without first giving the Board written notice at least thirty days in advance of any intent to cancel the bond.
(7) The Applicant/Principal and Surety may be served with notices, papers and other documents at the addresses given above.

I certify or declare under penalty of perjury, under the laws of the State of Nevada, that I have executed the foregoing bond on behalf of the Surety under an unrevoked power of attorney.

In witness whereof, each party to this bond has caused it to be executed on this 29th day of August, 2019.

APPLICANT/PRINCIPAL
Pharmsource Animal Health, LLC

Authorized Representative

SIGNED and SEALED in the presence of:

Witness

Witness

SURETY COMPANY
PLATTE RIVER INSURANCE COMPANY

Surety Company's Representative

Valerie Aber, Attorney-in-fact
print name

SIGNED and SEALED in the presence of:

Witness

Witness

Countersigned by:

N/A
Nevada Resident Agent

PLATTE RIVER INSURANCE COMPANY
POWER OF ATTORNEY

41417815

KNOW ALL MEN BY THESE PRESENTS, That the **PLATTE RIVER INSURANCE COMPANY**, a corporation of the State of Nebraska, having its principal offices in the City of Middleton, Wisconsin, does make, constitute and appoint

----------VALERIE ABER----------

its true and lawful Attorney(s)-in-fact, to make, execute, seal and deliver for and on its behalf, as surety, and as its act and deed, any and all bonds, undertakings and contracts of suretyship, provided that no bond or undertaking or contract of suretyship executed under this authority shall exceed in amount the sum of

----------ALL WRITTEN INSTRUMENTS IN AN AMOUNT NOT TO EXCEED: $20,000,000.00----------

This Power of Attorney is granted and is signed and sealed by facsimile under and by the authority of the following Resolution adopted by the Board of Directors of **PLATTE RIVER INSURANCE COMPANY** at a meeting duly called and held on the 8th day of January, 2002.

"**RESOLVED**, that the President, Executive Vice President, Vice President, Secretary or Treasurer, acting individually or otherwise, be and they hereby are granted the power and authorization to appoint by a Power of Attorney for the purposes only of executing and attesting bonds and undertakings, and other writings obligatory in the nature thereof, one or more resident vice-presidents, assistant secretaries and attorney(s)-in-fact, each appointee to have the powers and duties usual to such offices to the business of this company; the signature of such officers and seal of the Company may be affixed to any such power of attorney or to any certificate relating thereto by facsimile, and any such power of attorney or certificate bearing such facsimile signatures or facsimile seal shall be valid and binding upon the Company, and any such power so executed and certified by facsimile signatures and facsimile seal shall be valid and binding upon the Company in the future with respect to any bond or undertaking or other writing obligatory in the nature thereof to which it is attached. Any such appointment may be revoked, for cause, or without cause, by any of said officers, at any time."

In connection with obligations in favor of the Florida Department of Transportation only, it is agreed that the power and authority hereby given to the Attorney-in-Fact includes any and all consents for the release of retained percentages and/or final estimates on engineering and construction contracts required by the State of Florida Department of Transportation. It is fully understood that consenting to the State of Florida Department of Transportation making payment of the final estimate to the Contractor and/or its assignee, shall not relieve this surety company of any of its obligations under its bond.

In connection with obligations in favor of the Kentucky Department of Highways only, it is agreed that the power and authority hereby given to the Attorney-in-Fact cannot be modified or revoked unless prior written personal notice of such intent has been given to the Commissioner – Department of Highways of the Commonwealth of Kentucky at least thirty (30) days prior to the modification or revocation.

IN WITNESS WHEREOF, the **PLATTE RIVER INSURANCE COMPANY** has caused these presents to be signed by its officer undersigned and its corporate seal to be hereto affixed duly attested, this 3rd day of May, 2017.

Attest: John E. Rzepinski

John E. Rzepinski
Vice President, Treasurer & CFO

PLATTE RIVER INSURANCE COMPANY
CORPORATE
SEAL
NEBRASKA

PLATTE RIVER INSURANCE COMPANY

Stephen J. Sills
CEO & President

Suzanne M. Broadbent
Suzanne M. Broadbent
Assistant Secretary

STATE OF WISCONSIN }
COUNTY OF DANE } S.S.

On the 3rd day of May, 2017 before me personally came Stephen J. Sills, to me known, who being by me duly sworn, did depose and say: that he resides in the County of New York, State of New York; that he is President of **PLATTE RIVER INSURANCE COMPANY**, the corporation described in and which executed the above instrument; that he knows the seal of the said corporation; that the seal affixed to said instrument is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation and that he signed his name thereto by like order.

DAVID J. REGELE
NOTARY
PUBLIC
STATE OF WISCONSIN

David J. Regele

David J. Regele
Notary Public, Dane Co., WI
My Commission Is Permanent

STATE OF WISCONSIN }
COUNTY OF DANE } S.S.

I, the undersigned, duly elected to the office stated below, now the incumbent in **PLATTE RIVER INSURANCE COMPANY**, a Nebraska Corporation, authorized to make this certificate, **DO HEREBY CERTIFY** that the foregoing attached Power of Attorney remains in full force and has not been revoked; and furthermore, that the Resolution of the Board of Directors, set forth in the Power of Attorney is now in force.

Signed and sealed at the City of Middleton, State of Wisconsin this 29 day of AUGUST, 20 19.

PLATTE RIVER INSURANCE COMPANY
CORPORATE
SEAL
NEBRASKA

Antonio Celii

Antonio Celii
General Counsel, Vice President & Secretary

THIS DOCUMENT IS NOT VALID UNLESS PRINTED ON GREEN SHADED BACKGROUND WITH A RED SERIAL NUMBER IN THE UPPER RIGHT HAND CORNER. IF YOU HAVE ANY QUESTIONS CONCERNING THE AUTHENTICITY OF THIS DOCUMENT CALL 800-475-4450.

State Of Delaware

Entity Details

8/5/2019 9:39:33AM

File Number: 7149297
Incorporation Date / Formation Date: 11/15/2018
Entity Name: PHARMSOURCE ANIMAL HEALTH LLC
Entity Kind: Limited Liability Company
Entity Type: General
Residency: Domestic
State: DELAWARE
Status: Good Standing
Status Date: 11/15/2018

Registered Agent Information

Name: COGENCY GLOBAL INC.
Address: 850 NEW BURTON ROAD SUITE 201
City: DOVER
Country:
State: DE
Postal Code: 19904
Phone: 800-483-1140

Tax Information

Last AnnualReport Filed: 0
Tax Due: $ 0
Annual Tax Assessment: $300
Total Authorized Shares:

Filing History (Last 5 Filings)

Seq	Description	No of Pages	Filing Date mm/dd/yyyy	Filing Time	Effective Date mm/dd/yyyy
1	LLC	1	11/15/2018	11:51 AM	11/15/2018

COMPANY INFORMATION

Pharmsource AH is one of the most trusted veterinary distributors in the country. Our team has experience in the Animal Health industry and have established strong relationships with the leading manufacturers and hospitals throughout the country. We understand the importance of having a highly trained team and work hard to ensure that we are offering competitive prices, quick turnaround times, and superior customer service.

Monday – Fri 9 AM – 6 PM EST.

Management Overview

Title	Name
CEO (DR Supervisor)	Jeff Herman
COO	Ben Taylor
CCO & Designated Representative (DR)	John Peters
VP Purchasing	Maykel Fernendez
VP Sales – Pharmacy Division	David Schnettler
VP Sales – Animal Health	Dan McCoy
VP – Supply Chain	David Scott
Inventory Manager	Frank Dekle
Warehouse Manager	Damien Wilson
Customer Service Manager	
Human Resource Manager	
Sales Representative	
IT Specialist	Jason Doane
Warehouse Associate	

X

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 12-13-2018

Employer Identification Number:
83-2772322

Form: SS-4

Number of this notice: CP 575 A

For assistance you may call us at
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB OF THIS NOTICE.

001679.111772.322307.30660 1 MB 0.424 914

PHARMSOURCE ANIMAL HEALTH LLC
JEFFREY HERMAN SOLE MBR
123 NEWMAN DR STE A
BRUNSWICK GA 31520

001679

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 83-2772322. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear-off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 941	10/31/2019
Form 940	01/31/2020

If you have questions about the form(s) or the due dates(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, Accounting Periods and Methods.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, Entity Classification Election. See Form 8832 and its instructions for additional information.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/12/2019

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	CONTACT NAME: Susanne Harmon
McGinty-Gordon & Associates 225 Marina Drive PO Box 20668 St. Simons Island GA 31522	PHONE (A/C, No, Ext): (912) 289-9236 FAX (A/C, No): (912) 265-0322 E-MAIL ADDRESS: sharmon@mgassi.com

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Pharmsource LLC 123 Newman Dr Brunswick GA 31520	INSURER A: Selective Insurance Company	
	INSURER B: First Comp	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** CL1931213314 **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:			S2374260	03/04/2019	03/04/2020	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 500,000
							MED EXP (Any one person)	$ 15,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 3,000,000
								$
A	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			S2374260	03/04/2019	03/04/2020	COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Hired & NonOwned Liab	$ 1,000,000
A	[X] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [X] RETENTION $ 0			S2374260	03/04/2019	03/04/2020	EACH OCCURRENCE	$ 7,000,000
							AGGREGATE	$
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: Y If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		MWC007291604	12/23/2018	12/23/2019	[ ] PER STATUTE [ ] OTHER	
							E.L. EACH ACCIDENT	$ 100,000
							E.L. DISEASE - EA EMPLOYEE	$ 100,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

Susanne Harmon

© 1988-2015 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

4JJ

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR OUT-OF-STATE WHOLESALER 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 Wholesaler ☐ Ownership Change

(Please provide current license number if making changes: WH_____)

☐ 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

Facility Name: Eversana Life Science Services, LLC

Physical Address: 5650 Challenge Drive, Memphis, TN 38118

Mailing Address: 5650 Challenge Drive

City: Memphis State: TN Zip Code: 38118

Telephone: 901-370-5310 Fax: n/a

Toll Free Number: N/A

E-mail: Anthony.Brightman@eversana.com Website: www.eversana.com

Facility Manager: Anthony Wade Brightman II

Professional qualifications and experience of facility manager: SEE ATTACHED RESUME

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers

☐ Other: _____

Type of Products to be handled or wholesaled be firm:

☒ Legend Pharmaceuticals, Supplies or Devices

☐ Poisons or Chemicals

☐ Controlled Substances (include copy of DEA)

☐ Other: _____

☐ Hypodermic Devices

☐ Veterinary Legend Drugs

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

Is your company VAWD certified by NABP? Yes ☐ No ☒
(If yes, provide a copy of the certificate.)

Licensed as a Manufacturer by the FDA? Yes ☐ No ☒
(If yes, provide a copy of the FDA registration)

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 ☐

List the top 4 suppliers your company has been associated with in regards to pharmaceutical products that were sold, dispensed or distributed within the last year.

1) N/A - New facility
Name Address
Business

2)
Name Address
Business

3)
Name Address
Business

4)
Name Address
Business

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners 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 at least 10% interest or partners 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 at least 10% interest) or partners with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest) or partners 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 at least 10% interest or partners 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 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

John Vaughan
Print Name of Authorized Person

2-15-19
Date

Board Use Only	Received: _____	Amount: 500.00

120.75 FP fees

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: WI

Parent Company if any: LSCS Holdings, Inc.

Corporation Name: Eversana Life Science Services, LLC

Mailing Address: 5650 Challenge Drive

City: Memphis State: TN Zip: 38118

Telephone: 901-370-5310 Fax: _____

Contact Person: Anthony Wade Brightman II

For any corporation non publicly traded, disclose the following:

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

a) N/A
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

Anthony W. Brightman, II

Wild Dune Lane · Arlington, TN 38002 · (

TECHNICAL EXPERIENCE

Microsoft Office: Word, Excel, Outlook & Power Point; Red Prairie

PROFESSIONAL EXPERIENCE

Assistant Manager, DC Operations
Dohmen Life Science Services
Memphis, TN
June 2016-Present

- Manage Team of 175 Inbound and Outbound Operations employees for 750,000 sq. ft. DC
- Developed and implemented standardized processes for order processing, replenishments, shipping/receiving
- Develop and monitor productivity standards to ensure successful completion of sales orders for clients

Operations Supervisor
Dohmen Life Science Services
Memphis, TN
Dec 2008 –June 2016

- Supervise up to 40 Returns, Receiving, and Inventory Control associates
- Ensure product disposition, client receipts/releases, and client requests are fulfilled daily
- Manage client inventories including 25-30 returns of controlled substances weekly
- Certify Materials Management employees on all modes of Forklifts

EDUCATION

HOUSTON HIGH SCHOOL High School Diploma	Germantown, TN	June 1994
University of Arkansas	Fayetteville, AR	Aug 1994-Jan 1997
EMPORIA STATE UNIVERSITY Bachelor of Fine Arts in Communication	Emporia, KS	December 1999
Dale Carnegie Training	Memphis, TN	January 2009
CROWN Certified Forklift Trainer	Memphis, TN	July 2011

COMMUNITY INVOLVEMENT

Member, Kappa Alpha Psi Fraternity, Inc.	2003- Present
Member, Spirit Awakening Ministries in Memphis, TN	2005- Present
Volunteer, Ronald McDonald House	2011 – Present

References available upon request.

EVERSANA

EVERSANA Corporate Officers

NAME	TITLE	BUSINESS ADDRESS	PHONE	DOB
James Lang	CEO	3 Howe Road, Nahant, MA 01908		
Tim Guttman	CFO	190 N. Milwaukee St. Milwaukee, WI 53202		
Daniel Agroskin	Secretary/ Treasurer	245 Park Avenue, Suite 1601 New York, NY 10167		

Owner

LSCS Holdings, Inc., FEIN: 82-3870266 100 %

444 West Lake Street, Suite 1800, Chicago, IL 60606

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

EVERSANA LIFE SCIENCE SERVICES, LLC
TRACEY KESSLER
LICENSING/COMPLIANCE
8990 DUKE BLVD
MASON, OH 45040

October 22, 2019

Request Type: Certificate of Existence/Authorization
Request #: 0335376

Issuance Date: 10/22/2019
Copies Requested: 1

Document Receipt

Receipt # : 005072912

Filing Fee: $20.00

Payment-Credit Card - State Payment Center - CC #: 3767983310 $20.00

Regarding: **Eversana Life Science Services, LLC**

Filing Type: Limited Liability Company - Foreign
Formation/Qualification Date: 06/07/1995
Status: Active
Duration Term: Perpetual

Control # : 295825
Date Formed: 05/01/1995
Formation Locale: WISCONSIN
Inactive Date:

CERTIFICATE OF AUTHORIZATION

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

Eversana Life Science Services, LLC

* is a Limited Liability Company formed in the jurisdiction set forth above and is authorized to transact business in this State;

* has paid all fees, interest, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed an Application for Certificate of Withdrawal.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 035875935

DOM DIS
180 181 183

United States of America

State of Wisconsin

DEPARTMENT OF FINANCIAL INSTITUTIONS

To All to Whom These Presents Shall Come, Greeting:

I, Mary Ann McCoshen, Administrator of the Division of Corporate & Consumer Services of the Department of Financial Institutions, do hereby certify that

DOHMEN LIFE SCIENCE SERVICES, LLC

incorporated under the name DOHMEN FAMILY HOLDINGS COMPANY, LLC. and was a domestic corporation organized under the laws of this state and that its date of incorporation was September 24, 2008

I further certify that said corporation was merged out of existence into DDN/OBERGFEL, LLC effective January 1, 2014.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department on November 29, 2018.

MARY ANN McCOSHEN, Administrator
Division of Corporate and Consumer Services
Department of Financial Institutions

BY:

SURETY RIDER

To be attached to and form a part of

Bond No. 104803809

dated effective 11/1/2006
(MONTH-DAY-YEAR)

executed by Dohmen Life Science Services, LLC , as Principal,
(PRINCIPAL)

and by Travelers Casualty and Surety Company of America , as Surety,

in favor of State of Nevada, Nevada State Board of Pharmacy
(OBLIGEE)

in consideration of the mutual agreements herein contained the Principal and the Surety hereby consent to changing

The Principal name from: Dohmen Life Science Services, LLC

To: Eversana Life Science Services, LLC

and

Add the following location: 5650 Challenge Drive, Memphis, TN 38118

Nothing herein contained shall vary, alter or extend any provision or condition of this bond except as herein expressly stated.

This rider is effective 2/14/2019
(MONTH-DAY-YEAR)

Signed and Sealed 2/14/2019
(MONTH-DAY-YEAR)

Eversana Life Science Services, LLC
(PRINCIPAL)

By: _____
(PRINCIPAL)

Travelers Casualty and Surety Company of America
(SURETY)

By: _____
Rebecca Hobbs, Attorney-in-Fact

S-0443/GEEF 10/99

TRAVELERS

Travelers Casualty and Surety Company of America
Hartford, CT 06183

License No. WH00834 & WH00048

RIDER

To be attached to and form part of Bond No. 104803809.

Issued on behalf of DDN/Obergfel, LLC as Principal, and in favor of NEVADA STATE BOARD OF PHARMACY as Obligee.

It is agreed that:

☒ 1. The Surety hereby gives its consent to change the Name:

from: DDN/Obergfel, LLC

to: Dohmen Life Science Services, LLC

☒ 2. The Surety hereby gives its consent to change the Address:

from: N114 W 18850 CLINTON DRIVE GERMANTOWN, WI 53022

to: 800 WOODLAND PRIME, SUITE 200 MENOMONEE FALLS, WI 53051

☒ 3. The Surety hereby gives its consent to change the License No.:

from: WH00834 & WH00048

to: WH00834, WH00048, WH01311

This rider shall become effective as of January 01, 2014

PROVIDED, however, that the liability of the Surety under the attached bond as changed by this rider shall not be cumulative.

Signed, sealed and dated February 07, 2014.

Travelers Casualty and Surety Company of America

By: _____
Joseph L. Nespor
Attorney-in-Fact

Accepted: NEVADA STATE BOARD OF PHARMACY
Obligee

By: _____

Dohmen Life Science Services, LLC
Principal

By: _____

S-4111 (8/66)

NEVADA STATE BOARD OF PHARMACY

555 Double Eagle Court #1100
Reno, Nevada 89521
(775) 850-1440
Fax: (775) 850-1444

PHARMACEUTICAL WHOLESALER SURETY BOND

Bond No. 104803809

Application/License No. WH00834 & WH00048

DDN/Obergfel, LLC (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is N114 W 18850 Clinton Dr., Germantown, WI 53022 (Address of Applicant/Principal), as PRINCIPAL, and Travelers Casualty and Surety Company of America (Surety Company), a corporation organized under the laws of the state of Connecticut (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is 215 Shuman Blvd., Naperville, IL 60563 (Address of Surety) as SURETY, are held and firmly bound unto the State of Nevada and to the Nevada State Board of Pharmacy for the penal sum of ONE HUNDRED THOUSAND DOLLARS ($100,000.00), for which payment we bind ourselves, our heirs, executors, administrators, successors and assigns jointly and severally, by these presents. This bond term shall become effective on 11/1/2006 (Effective Date).

WHEREAS, the provisions of Nevada Revised Statutes (NRS) 639.515 require that the Applicant/Principal file or have on file with the Nevada State Board of Pharmacy (Board) a bond in the sum of $100,000.00 payable to the Nevada State Board of Pharmacy and this bond is executed and tendered in accordance therewith. This bond secures payment of any administrative fines imposed by the Board pursuant to NRS 639.255 and any costs incurred by the Board regarding the license of Applicant/Principal that are impose pursuant to NRS 622.400 or 622.410 which the Applicant/Principal fails to pay.

THIS BOND is subject to the following conditions:

(1) This bond shall be deemed continuous in form and shall remain in full force and effect and shall run concurrently with the license period for which the license is granted and each and every succeeding license period or periods for which said Applicant/Principal

may be licensed, after which liability hereunder shall cease except as to any liability or indebtedness therefore incurred or accrued hereunder.

(2) This bond is executed by the Applicant/Principal and the Surety to comply with the provisions of NRS 639.515 and said bond shall be subject to all of the terms and provisions thereof.

(3) The Surety, its successors and assigns, are jointly and severally liable on the obligations of the bond.

(4) The limitations of the liability of the Surety and the conditions of the bond are set forth in NRS 639.515. Any claim by the Board may be made directly to the Surety and need not be preceded by the filing of any action in a proper court. Payment of any such claim shall be payable to the Nevada State Board of Pharmacy.

(5) The aggregate liability of the Surety hereunder on all claims whatsoever shall not exceed the penal sum of this bond in any event.

(6) This bond may not be cancelled by the Surety without first giving the Board written notice at least thirty days in advance of any intent to cancel the bond.

(7) The Applicant/Principal and Surety may be served with notices, papers and other documents at the addresses given above.

I certify or declare under penalty of perjury, under the laws of the State of Nevada, that I have executed the foregoing bond on behalf of the Surety under an unrevoked power of attorney.

In witness whereof, each party to this bond has caused it to be executed on this 6 day of October, 20 06.

APPLICANT/PRINCIPAL
DDN/Obergfel, LLC

Authorized Representative

SURETY COMPANY
Travelers Casualty and Surety Company of America

Surety Company's Representative

C.R. Hernandez, Attorney-in-fact
print name

SIGNED and SEALED in the presence of:

Witness

Witness

SIGNED and SEALED in the presence of:

Witness

Witness

Countersigned by:

Nevada Resident Agent 10/9/06
Countersigned for Nevada By
Marsh USA, Inc.
Michele Robertson, Resident Agent

STATE OF ILLINOIS
COUNTY OF COOK

I, Beatriz Polito, a Notary Public in and for said County, do hereby

certify that C.R. Hernandez Attorney-in-Fact, of the:

Farmington Casualty Company	**A Connecticut Corporation**
Fidelity and Guaranty Insurance Company	**An Iowa Corporation**
Fidelity and Guaranty Insurance Underwriters, Inc.	**A Wisconsin Corporation**
Seaboard Surety Company	**A New York Corporation**
St. Paul Fire and Marine Insurance Company	**A Minnesota Corporation**
St. Paul Guardian Insurance Company	**A Minnesota Corporation**
St. Paul Mercury Insurance Company	**A Minnesota Corporation**
Travelers Casualty and Surety Company	**A Connecticut Corporation**
Travelers Casualty and Surety Company of America	**A Connecticut Corporation**
United States Fidelity and Guaranty Company	**A Maryland Corporation**

who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that they signed, sealed, and delivered said instrument for and on behalf of:

Farmington Casualty Company	**A Connecticut Corporation**
Fidelity and Guaranty Insurance Company	**An Iowa Corporation**
Fidelity and Guaranty Insurance Underwriters, Inc.	**A Wisconsin Corporation**
Seaboard Surety Company	**A New York Corporation**
St. Paul Fire and Marine Insurance Company	**A Minnesota Corporation**
St. Paul Guardian Insurance Company	**A Minnesota Corporation**
St. Paul Mercury Insurance Company	**A Minnesota Corporation**
Travelers Casualty and Surety Company	**A Connecticut Corporation**
Travelers Casualty and Surety Company of America	**A Connecticut Corporation**
United States Fidelity and Guaranty Company	**A Maryland Corporation**

for the uses and purposed therein set forth.

Given under my hand and notarial seal at my office in the City of **Chicago** in said County, this 6 day of October A.D of 2006

Beatriz Polito

Notary Public

"OFFICIAL SEAL"
BEATRIZ POLITO
Notary Public, State of Illinois
My Commission Expires 5/14/07

SURETY RIDER

To be attached to and form a part of

Bond No. 104803809

dated effective 11/1/2006
(MONTH-DAY-YEAR)

executed by Dohmen Life Science Services, LLC , as Principal,
(PRINCIPAL)

and by Travelers Casualty and Surety Company of America , as Surety,

in favor of State of Nevada, Nevada State Board of Pharmacy
(OBLIGEE)

in consideration of the mutual agreements herein contained the Principal and the Surety hereby consent to changing

The Principal name from: Dohmen Life Science Services, LLC

To: Eversana Life Science Services, LLC

and

Add the following location: 5650 Challenge Drive, Memphis, TN 38118

Nothing herein contained shall vary, alter or extend any provision or condition of this bond except as herein expressly stated.

This rider is effective 2/14/2019
(MONTH-DAY-YEAR)

Signed and Sealed 2/14/2019
(MONTH-DAY-YEAR)

Eversana Life Science Services, LLC
(PRINCIPAL)

By: _____
(PRINCIPAL)

Travelers Casualty and Surety Company of America
(SURETY)

By: _____
Rebecca Hobbs, Attorney-in-Fact

S-0443/GEEF 10/99

TRAVELERS

Travelers Casualty and Surety Company of America
Travelers Casualty and Surety Company
St. Paul Fire and Marine Insurance Company

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company are corporations duly organized under the laws of the State of Connecticut (herein collectively called the "Companies"), and that the Companies do hereby make, constitute and appoint Rebecca Hobbs, of Knoxville, Tennessee, their true and lawful Attorney-in-Fact to sign, execute, seal and acknowledge any and all bonds, recognizances, conditional undertakings and other writings obligatory in the nature thereof on behalf of the Companies in their business of guaranteeing the fidelity of persons, guaranteeing the performance of contracts and executing or guaranteeing bonds and undertakings required or permitted in any actions or proceedings allowed by law.

IN WITNESS WHEREOF, the Companies have caused this instrument to be signed, and their corporate seals to be hereto affixed, this **3rd** day of **February, 2017.**

State of Connecticut

City of Hartford ss.

By: _____
Robert L. Raney, Senior Vice President

On this the **3rd** day of **February, 2017**, before me personally appeared **Robert L. Raney**, who acknowledged himself to be the Senior Vice President of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.

My Commission expires the **30th** day of **June, 2021**

Marie C. Tetreault
Marie C. Tetreault, Notary Public

This Power of Attorney is granted under and by the authority of the following resolutions adopted by the Boards of Directors of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, which resolutions are now in full force and effect, reading as follows:

RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President, any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary may appoint Attorneys-in-Fact and Agents to act for and on behalf of the Company and may give such appointee such authority as his or her certificate of authority may prescribe to sign with the Company's name and seal with the Company's seal bonds, recognizances, contracts of indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any of said officers or the Board of Directors at any time may remove any such appointee and revoke the power given him or her; and it is

FURTHER RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President may delegate all or any part of the foregoing authority to one or more officers or employees of this Company, provided that each such delegation is in writing and a copy thereof is filed in the office of the Secretary; and it is

FURTHER RESOLVED, that any bond, recognizance, contract of indemnity, or writing obligatory in the nature of a bond, recognizance, or conditional undertaking shall be valid and binding upon the Company when (a) signed by the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary and duly attested and sealed with the Company's seal by a Secretary or Assistant Secretary; or (b) duly executed (under seal, if required) by one or more Attorneys-in-Fact and Agents pursuant to the power prescribed in his or her certificate or their certificates of authority or by one or more Company officers pursuant to a written delegation of authority; and it is

FURTHER RESOLVED, that the signature of each of the following officers: President, any Executive Vice President, any Senior Vice President, any Vice President, any Assistant Vice President, any Secretary, any Assistant Secretary, and the seal of the Company may be affixed by facsimile to any Power of Attorney or to any certificate relating thereto appointing Resident Vice Presidents, Resident Assistant Secretaries or Attorneys-in-Fact for purposes only of executing and attesting bonds and undertakings and other writings obligatory in the nature thereof, and any such Power of Attorney or certificate bearing such facsimile signature or facsimile seal shall be valid and binding upon the Company and any such power so executed and certified by such facsimile signature and facsimile seal shall be valid and binding on the Company in the future with respect to any bond or understanding to which it is attached.

I, **Kevin E. Hughes**, the undersigned, Assistant Secretary of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, do hereby certify that the above and foregoing is a true and correct copy of the Power of Attorney executed by said Companies, which remains in full force and effect.

Dated this 14th day of February, 2019.

Kevin E. Hughes, Assistant Secretary

To verify the authenticity of this Power of Attorney, please call us at 1-800-421-3880.
Please refer to the above-named Attorney-in-Fact and the details of the bond to which the power is attached.

Marsh

Jurisdiction	License	Number	Department	Renewal
State of Arkansas	Nonresident Wholesale Drug Distributor	WD05185	Board of Pharmacy	12/31/2020
State of Connecticut	Nonresident Wholesale Drug Distributor	CSW.0004417	License Services Division	6/30/2019
State of Illinois	Nonresident Wholesale Drug Distributor	004004759	Department of Business and Professional Regulation	12/31/2020
State of Kansas	Nonresident Wholesale Drug Distributor	5-108834	Board of Pharmacy	6/30/2019
State of Kentucky	Nonresident Wholesale Drug Distributor	W04241	Board of Pharmacy	9/30/2019
State of Louisiana	Nonresident Wholesale Drug Distributor	9596	Board of Wholesale Drug Distributors	12/31/2019
State of Maine	Nonresident Wholesale Drug Distributor	WH70003009	Board of Pharmacy	12/31/2019
State of Minnesota	Nonresident Wholesale Drug Distributor	364131	Board of Pharmacy	5/31/2019
State of North Carolina	Nonresident Wholesale Drug Distributor	088	Food and Drug Protection Division	12/31/2019
State of New Hampshire	Nonresident Wholesale Drug Distributor	06602	Board of Pharmacy	6/30/2019
State of Oklahoma	Nonresident Wholesale Drug Distributor	88-W-5827	Board of Pharmacy	4/30/2020
State of Pennsylvania	Nonresident Wholesale Drug Distributor	3000010010	Drug and Device Registration Division	4/30/2020
State of Rhode Island	Nonresident Wholesale Drug Distributor	DIS03271	Board of Pharmacy	9/30/2019
State of South Dakota	Nonresident Wholesale Drug Distributor	600-3016	Board of Pharmacy	12/31/2019
State of Tennessee	Nonresident Wholesale Drug Distributor	00005284	Division of Health Related Boards	01/31/2021
State of Texas	Nonresident Wholesale Drug Distributor	1002700	Food and Drug Licensing	3/13/2021
State of Utah	Nonresident Wholesale Drug Distributor	11195126-1710	Occupational and Professional Licensing	9/30/2021
State of Vermont	Nonresident Wholesale Drug Distributor	039.134313	Board of Pharmacy	7/31/2019
State of Washington	Nonresident Wholesale Drug Distributor	PHWH.FX.60944622	Department of Health	9/30/2019
State of West Virginia	Nonresident Wholesale Drug Distributor	WD0559942	Board of Pharmacy	6/30/2019

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS

ID NUMBER: 0000005284
EXPIRATION DATE: 01/31/2021

This is to certify that all requirements of the State of Tennessee have been met.

PHARMACY BOARD
WHOLESALE/DISTRIBUTOR
EVERSANA LIFE SCIENCE SERVICES

COMMISSIONER OF HEALTH

TRACEY KESSLER
EVERSANA LIFE SCIENCE SERVICES
LLC 5650 CHALLENGE DR
MEMPHIS TN 38118

11565687

26185

State of Tennessee
Department of Health

TENNESSEE BOARD OF PHARMACY
WHOLESALE/DISTRIBUTOR
EVERSANA LIFE SCIENCE SERVICES
LLC 5650 CHALLENGE DR
MEMPHIS TN 38118

This is to certify that all requirements of the State of Tennessee have been met.

ID NUMBER: 0000005284
EXPIRATION DATE: 01/31/2021

INTERIM DIRECTOR, HEALTH RELATED BOARDS

COMMISSIONER

DCF171

4KK

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **non-transferable checks 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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH_____

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

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7

☒ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: YS Marketing inc dba Numed

Physical Address: 265 S. Pioneer Blvd

City: Springboro State: OH Zip Code: 45066

Telephone Number: 718-778-6080 Fax Number: 888-278-8504

Toll Free Number: _____

E-mail: todd.Pointer@numedpharma.com Website: www.numedpharma.com

Facility Manager: Todd Pointer

Professional qualifications and experience of facility manager: see attached

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☐ Wholesalers

☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices

☐ Poisons or Chemicals ☒ Veterinary Legend Drugs

☐ Controlled Substances (include copy of DEA)

☐ Other: _____

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership

Is your company VAWD certified by NABP? Yes ☐ No ☒
(If yes, provide a copy of the certificate)

Licensed as Manufacturer by the FDA? Yes ☐ No ☒
(If yes, provide a copy of your FDA registration)

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 ☐

List the top 4 suppliers your company has been associated with regards to pharmaceutical products that were sold, dispensed or distributed with the last year.

Name: Lupin Pharmaceuticals, INC
Address: 111 South Calvert street, Suite 2150 Baltimore MD 21202

Name: Perrigo Pharmaceuticals
Address: 515 Eastern Ave. Allegan, Michigan 49010

Name: Aurobindo Pharma USA inc
Address: 6 Wheeling Road Dayton NJ 08810

Name: Cipla USA inc
Address: 1560 Sawgrass corporate Parkway, suite 130 Sunrise FL 33323

A licensee is not required to have a Nevada State Business License, however, if you do, please provide the number: _____

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 ☒

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

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.

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

Joel Silberstein
Print Name of Authorized Person

11/6/2019
Date

Board Use Only	Date Processed:_____	Amount: _____

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: NY

Parent Company if any: _____

Mailing Address: 2004 McDonald Ave

City: Brooklyn State: NY Zip: 11223

Telephone: 718-778-6080 Fax: 888-278-8504

Contact Person: Joel Silberstein

For any corporation non-publicly traded, disclose the following:

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

a) Joel Silberstein 2004 McDonald Ave Brooklyn NY 11223 100% ownership
Name Business Address

b) _____
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. 200

3) What was the price paid per share? $10

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

Include with the application for a non-publicly traded corporation

List of officers and directors

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.

STATE OF OHIO
BOARD OF PHARMACY

LICENSE TO DISTRIBUTE DANGEROUS DRUGS

The entity named below is duly licensed, and is entitled to conduct business in the state of Ohio until June 30, 2021.

YS Marketing Inc.

Numed

265 S Pioneer Blvd

Springboro, OH 45066-1180

License Number: 0130000086

Wholesaler - Category 2

Expiration Date: June 30, 2021

CLASS: Wholesaler - Category 2
BUSINESS TYPE: FS – Full Service

Responsible Person – Print, sign and keep license in a readily retrievable location at the address listed on this license.

Responsible Person Name (Print)	Signature of Responsible Person
PESACHYA KLINKOWITZ	

Any change of responsible person must be reported within ten days of the effective date of the appointment of the new responsible person via Service Request on your Ohio eLicense Dashboard - https://elicense.ohio.gov/oh_homepage.

State of Ohio Board of Pharmacy
77 South High Street, 17th Floor, Columbus, Ohio 43215
T: 614/466-4143 | F: 614/752-4836 | licensing@pharmacy.ohio.gov

numed
PHARMA

YS Marketing Inc
2004 McDonald Avenue
Brooklyn, NY 11223

To Whom it May Concern,

The following positions are held by:

President – Joel Silberstein

Secretary – Joel Silberstein

Treasurer- Joel Silberstein

Thank you,

Joel Silberstein, CEO

numed
PHARMA

YS Marketing Inc
2004 McDonald Avenue
Brooklyn, NY 11223

List of who handles drugs daily:

Todd Pointer

UNITED STATES OF AMERICA
STATE OF OHIO
OFFICE OF THE SECRETARY OF STATE

I, Frank LaRose, do hereby certify that I am the duly elected, qualified and present acting Secretary of State for the State of Ohio, and as such have custody of the records of Ohio and Foreign business entities; that said records show YS MARKETING INC, a New York corporation, having qualified to do business within the State of Ohio on February 22, 2019 under License No. 4297343 is currently in GOOD STANDING upon the records of this office.

Witness my hand and the seal of the Secretary of State at Columbus, Ohio this 31st day of October, A.D. 2019.

Ohio Secretary of State

Validation Number: 201930401014

SURETEC INSURANCE COMPANY

2103 CityWest Boulevard, Suite 1300, Houston, TX 77042

RIDER

TO BE ATTACHED AND FORM A PART OF:

Bond No. 3406443

issued by SureTec Insurance Company

in favor of the State of Nevada

on behalf of YS Marketing, Inc

In consideration of the premium charged, it is understood and agreed that:

Effective 10/24/2019:

Adding a Second Location of:

265 S. Pioneer Blvd., Springboro, OH 45066

PROVIDED, HOWEVER, that the liability of SureTec Insurance Company, under the attached bond as changed by this Rider shall not be cumulative.

Nothing herein contained shall be held to vary, waive, alter or extend any of the terms, conditions, agreements or warranties of the above mentioned bond, other than as stated above.

Signed this 1st day of November, 2019.

SureTec Insurance Company, Surety

By: _____

Steven M. Varga, *Attorney in Fact*

POA #: 3810001

SureTec Insurance Company
LIMITED POWER OF ATTORNEY

Know All Men by These Presents, That SURETEC INSURANCE COMPANY (the "Company"), a corporation duly organized and existing under the laws of the State of Texas, and having its principal office in Houston, Harris County, Texas, does by these presents make, constitute and appoint John D. Weisbrot, Melissa L. McDade, Steven M. Varga

its true and lawful Attorney-in-fact, with full power and authority hereby conferred in its name, place and stead, to execute, acknowledge and deliver any and all bonds, recognizances, undertakings or other instruments or contracts of suretyship to include waivers to the conditions of contracts and consents of surety for, providing the bond penalty does not exceed

Five Hundred Thousand and 00/100 Dollars ($500,000.00)

and to bind the Company thereby as fully and to the same extent as if such bond were signed by the CEO, sealed with the corporate seal of the Company and duly attested by its Secretary, hereby ratifying and confirming all that the said Attorney-in-Fact may do in the premises. Said appointment is made under and by authority of the following resolutions of the Board of Directors of the SureTec Insurance Company:

Be it Resolved, that the President, any Vice-President, any Assistant Vice-President, any Secretary or any Assistant Secretary shall be and is hereby vested with full power and authority to appoint any one or more suitable persons as Attorney(s)-in-Fact to represent and act for and on behalf of the Company subject to the following provisions:

Attorney-in-Fact may be given full power and authority for and in the name of and of behalf of the Company, to execute, acknowledge and deliver, any and all bonds, recognizances, contracts, agreements or indemnity and other conditional or obligatory undertakings and any and all notices and documents canceling or terminating the Company's liability thereunder, and any such instruments so executed by any such Attorney-in-Fact shall be binding upon the Company as if signed by the President and sealed and effected by the Corporate Secretary.

Be it Resolved, that the signature of any authorized officer and seal of the Company heretofore or hereafter affixed to any power of attorney or any certificate relating thereto by facsimile, and any power of attorney or certificate bearing facsimile signature or facsimile seal shall be valid and binding upon the Company with respect to any bond or undertaking to which it is attached. *(Adopted at a meeting held on 20th of April, 1999.)*

In Witness Whereof, SURETEC INSURANCE COMPANY has caused these presents to be signed by its CEO, and its corporate seal to be hereto affixed this 7th day of November, A.D. 2018.

SURETEC INSURANCE COMPANY

By: _____
John Knox Jr., CEO

State of Texas ss:
County of Harris

On this 7th day of November, A.D. 2018 before me personally came John Knox Jr., to me known, who, being by me duly sworn, did depose and say, that he resides in Houston, Texas, that he is CEO of SURETEC INSURANCE COMPANY, the company described in and which executed the above instrument; that he knows the seal of said Company; that the seal affixed to said instrument is such corporate seal; that it was so affixed by order of the Board of Directors of said Company; and that he signed his name thereto by like order.

JACQUELYN GREENLEAF
Notary Public, State of Texas
Comm. Expires 05-18-2021
Notary ID 126903029

_____
Jacquelyn Greenleaf, Notary Public
My commission expires May 18, 2021

I, M. Brent Beaty, Assistant Secretary of SURETEC INSURANCE COMPANY, do hereby certify that the above and foregoing is a true and correct copy of a Power of Attorney, executed by said Company, which is still in full force and effect; and furthermore, the resolutions of the Board of Directors, set out in the Power of Attorney are in full force and effect.

Given under my hand and the seal of said Company at Houston, Texas this 1st day of November, 2019, A.D.

_____
M. Brent Beaty, Assistant Secretary

Any instrument issued in excess of the penalty stated above is totally void and without any validity. 3810001
For verification of the authority of this power you may call (713) 812-0800 any business day between 8:30 am and 5:00 pm CST.



Markel Insurance Company
Ten Parkway North
Deerfield, Illinois 60015

FINANCIAL STATEMENT
as of December 31, 2018
Statutory Basis

Bonds	$ 1,025,428,511	Reserve for Losses and Loss Expense	$ 901,038,609
Stocks	1,122,158,922	Reserve for Unearned Premiums	260,093,070
Cash & Short Term Investments	58,619,623	Other Liabilities	111,549,664
Agents Balances or Uncollected Premiums	163,224,243	TOTAL LIABILITIES	1,272,681,343
Other Admitted Assets	95,650,740		
		Capital Stock	4,200,000
		Surplus	1,188,200,696
		TOTAL POLICYHOLDERS SURPLUS	1,192,400,696
		TOTAL LIABILITIES AND POLICYHOLDERS	
TOTAL ASSETS	$ 2,465,082,039	SURPLUS	$ 2,465,082,039

Bonds and stocks are valued in accordance with the basis adopted by the National Association of Insurance Commissioners.
Securities carried in the above statement are deposited as required by law.

CERTIFICATE

Justin Patrick Broussard, Assistant Treasurer, and Michael John Jaeger, Controller, of the Markel Insurance Company, being duly sworn each for himself, deposes and says that they are the above described officers of the said Company and that on the 31st day of December, 2018, the Company actually possessed the assets set forth in the foregoing financial statement, except as hereinbefore indicated, and that the foregoing statement is a correct exhibit of such assets and liabilities of said Company on the 31st day of December, 2018, according to the best of their information, knowledge and belief.

Controller

Assistant Treasurer

STATE OF VIRGINIA
COUNTY OF HENRICO

On this 16th day of April, 2019, before me came the above named officers of Markel Insurance Company to me known to be the individuals and officers described herein, and acknowledge that they executed the foregoing instrument and affixed the seal of the corporation thereto by the authority of their office.

Notary Public





TODD POINTER
N. US Hwy. 68
Wilmington, OH 45177
Cell: [redacted]

PROFESSIONAL EXPERIENCE

NUMED, Springboro, OH **2019-Current**

Director of Operations
Manage company operations.
- Maintain inventory for over 5,350 items (Rx, OTC and HHC).
- Manages the process of filling customers' orders and prepare orders for delivery.
- Manages the process of receiving and put-away of daily inventory.
- Manages the process of returns from customers/vendors, issuance of credit, recalls and sending outdated/expired products back to the manufacturer for credit/disposal.
- Coordinate building, equipment and vehicle maintenance with outside vendors.
- Assisted with updating work method S.O.P. to document current policies and procedures.

SKYRX, LLC, Springboro, OH **2019-2019**

Director of Operations
Manage company operations.
- Maintain inventory for over 5,750 items (CII, CIII, CIV, CV, Rx, OTC and HHC).
- Manages the process of filling customers' orders and prepare orders for delivery.
- Manages the process of receiving and put-away of daily inventory.
- Manages the process of returns from customers/vendors, issuance of credit, recalls and sending outdated/expired products back to the manufacturer for credit/disposal.
- Coordinate building, equipment and vehicle maintenance with outside vendors.
- Assisted with updating work method S.O.P. to document current policies and procedures.

MIAMI-LUKEN, INC., Springboro, OH **2015-2019**

Transportation & Warehouse Supervisor (Days)
Manage company operations.
- Receiving product, stocking product, picking product, pharmacy deliveries and customer returns.
- Maintain inventory for over 11,000 items (CII, CIII, CIV, CV, Rx, OTC, HHC and Candy).
- Manages the process of filling customers' orders and prepare orders for delivery.
- Manages the process of receiving and put-away of daily inventory.
- Manages the process of returns from customers/vendors, issuance of credit, recalls and sending outdated/expired products back to the manufacturer for credit/disposal.
- Coordinate building, equipment and vehicle maintenance with outside vendors.
- Assisted with updating work method S.O.P. to document current policies and procedures.

ALL FOOD EQUIPMENT, LLC, Columbia, TN **2015-2015**

Sales Manager and Customer Service
Manage company operations.
- Inventory and organize used bakery equipment.
- Initial sales contact, running flyers and specials with new and some existing customers.
- Quotes on used items or new lines of equipment.
- Handle warranty calls and coordinate service follow-ups or warranty issues.

ALASKA GOURMET COOKIES, LLC, Fairbanks, AK **2014-2015**

Operations, Bookkeeping, Marketing, Sales, Purchasing, Logistics, and IT
Manage company operations.
- Create and maintain company's website.
- Conducted on-the-job training to maintain methods and DEC and OSHA compliance.
- Authored and maintained forms to reflect changes in work standards and introduction of new work methods.
- Created work method S.O.P. to document current policies and procedures.

TOTAL BAKING SOLUTIONS, LLC, Wilmington, OH **2011-2014**

Marketing, Sales, Purchasing, Logistics, and IT
Manage company website and advertising.
- Create and maintain company's website.
- Create daily and weekly email and fax advertising for previously owned bakery equipment.
- Maintain a comprehensive database of existing bakery companies globally.
- Author formal price quotes for previously owned bakery equipment.

WORKFORCE SERVICES UNLIMITED, Wilmington, OH **2009-2011**

Computer Training Specialist
Facilitate computer classes for displaced employees.
- Facilitated Microsoft Office training classes for displaced workers.
- Adapted teaching styles and methods to accommodate the needs and abilities of students.

ABX AIR, INC. (formerly Airborne Express), Wilmington, OH **2000-2009**

Ground Operations Trainer 2003-2009
Facilitate training classes for new hires and existing employees.
- Conducted formal and on-the-job training to maintain methods, FAA and OSHA compliance.
- Drafted work method S.O.P.'s to document new or revised policies and procedures.
- Authored, improved and maintained training presentations and forms.
- Maintained a comprehensive database of training records for over fifteen thousand employees to track completion dates of all employee training.
- Assisted in the completion of projects to implement organizational changes.
- Submitted department performance and statistical reports to fulfill the informational needs of corporate headquarters.

Lead Sorter 2000-2002
Manage a team of workers in a fast-paced shipping environment.

Sorter 2000-2000
Sort packages and load onto cargo aircraft.

EDUCATION

Bachelor of Science degree in **eMarketing (Summa Cum Laude)**
Franklin University, Columbus, OH

Associates of Science degree in **Business Management/Computer Programming**
Southern State Community College, Hillsboro, OH

PROFESSIONAL DEVELOPMENT

Topflight Leadership Course, Adobe Training, Train-the-Trainer Training

COMPUTER SKILLS

IBM AS/400, Microsoft Windows 10, Word, Excel, PowerPoint, Access, Outlook, Publisher, Visio, Lotus Quickplace, Aptana, Kompozer, Nvu, Adobe Acrobat, Captivate, Dreamweaver, Flash, Illustrator, InDesign, Photoshop Elements, QuickBooks

AWARDS AND RECOGNITION

Letters of Recognition (2), Perfect Attendance Awards (8)

REFERENCES

Michael Faul (former CEO of Miami-Luken, Inc.)

4LL

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 208, Reno, NV 89521

APPLICATION FOR OUT-OF-STATE WHOLESALER 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 Wholesaler or ☐ Ownership Change (Provide current license number if making changes: WH_____
Check box below for type of ownership and complete all required forms for type of ownership that you have selected. If LLC use Non Public Corporation or Partnership

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,7
☑ Non Publicly Traded Corporation – Pages 1,2,3,5,6 ☐ Sole Owner – Pages 1,2,3,8

GENERAL INFORMATION to be completed be all types of ownership

Facility Name: Medical Supply Distribution, LLC

Physical Address: 2340 Adamsville Rd

City: Zanesville OH State: Zip Code: 43701 Telephone Number: (855)487-1148 Fax Number: _____

Toll Free Number: (855)487-1148

E-mail: brittany@medsupplydistribution.com Website: medsupplydistribution.com

Facility Manager: _____

Professional qualifications and experience of facility manager: _____

Types of licensed outlets or authorized persons firm will serve:

☑ Pharmacies ☑ Practitioners ☑ Hospitals ☐ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☐ Legend Pharmaceuticals, Supplies or Devices
☐ Poisons or Chemicals
☐ Controlled Substances (include copy of DEA)
☐ Hypodermic Devices
☐ Veterinary Legend Drugs
☐ Other: _____

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership

Is your company VAWD certified by NABP? Yes ☐ No ☑
(If yes, provide a copy of the certificate)

Licensed as Manufacturer by the FDA? Yes ☐ No ☑
(If yes, provide a copy of your FDA registration)

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 ☑

List the top 4 suppliers your company has been associated with regards to pharmaceutical products that were sold, dispensed or distributed with the last year.

Name: ABO Pharmaceuticals
Address: 7930 Arjons Dr Ste A San Diego, CA 92126

Name: Med Ex Supply
Address: 61 Willet St. Passaic, NJ 07055

Name: Med Plus Services (NDC) USA
Address: 402 BNA Drive Suite 500 Nashville, TN 37217

Name:
Address:

A licensee is not required to have a Nevada State Business License, however, if you do, please provide the number: _____

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 ☑

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

This page must be submitted for all types of ownership.

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

Matthew C. Brandt
Print Name of Authorized Person

9/5/19
Date

Board Use Only	Date Processed:_____	Amount: $500.00 finger prints $36.75

Check no. 2013524463

$36.75 returned on 9/26/19
DB

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Ohio

Parent Company if any: _____

Mailing Address: 2340 Adamsville Road

City: Zanesville State: Ohio Zip: 43701

Telephone: (855) 487-1148 Fax: (740) 487-1940

Contact Person: Brittany Adams

For any corporation non publicly traded, disclose the following:

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

a) Matthew C. Brandt 2340 Adamsville Road Zanesville, Oh. 43701
Name Business Address

b) Dale R. Edwards 2340 Adamsville Road Zanesville, Oh. 43701
Name Business Address

c) _____
Name Business Address

d) _____
Name Business Address

2) Provide the number of shares issued by the corporation. a) 80 % b) 20 %

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

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

Include with the application for a non publicly traded corporation

List of officers and directors

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.

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

Type of Partnership: General _____ Limited ✓

List names of 4 largest partners and percentage of ownership:

Name: Matthew C. Brandt %: 80

Name: Dale R. Edwards %: 20

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: _____

Mailing Address: _____

City, State Zip Code: _____

Telephone Number: _____ Fax Number: _____

Contact Person: _____

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

Include with the application for a partnership

***If VAWD certified by NABP, fingerprints, list of employees and bond are not required. Please provide a copy of your VAWD certification.

***If you are a FDA registered manufacturer, fingerprints, list of employees and bond are not required. Please provide a copy of your FDA registration.

If your company is not VAWD certified by NABP, or an FDA registered manufacturer you will need to complete the following:

Submit fingerprints – Please refer to Page 9 for Fingerprint Submission Instructions.

Submit a list containing each employee(s) who handle the drugs on a daily basis.

Copy of a bond in an amount of $100,000.00 made payable to the State of Nevada. A bond or other form of security must be current in order to maintain and keep a Nevada wholesaler registration. Blank surety bond, certificate of deposit, letter of credit or cash deposit are included under the new application tab entitled "Wholesalers Only".

UNITED STATES OF AMERICA
STATE OF OHIO
OFFICE OF THE SECRETARY OF STATE

I, Frank LaRose, do hereby certify that I am the duly elected, qualified and present acting Secretary of State for the State of Ohio, and as such have custody of the records of Ohio and Foreign business entities; that said records show MEDICAL SUPPLY DISTRIBUTION LLC, an Ohio For Profit Limited Liability Company, Registration Number 3960076, was organized within the State of Ohio on November 15, 2016, is currently in FULL FORCE AND EFFECT upon the records of this office.



Witness my hand and the seal of the Secretary of State at Columbus, Ohio this 29th day of October, A.D. 2019.

Ohio Secretary of State

Validation Number: 201930201314

UNITED STATES OF AMERICA
STATE OF OHIO
OFFICE OF THE SECRETARY OF STATE

I, Jon Husted, do hereby certify that I am the duly elected, qualified and present acting Secretary of State for the State of Ohio, and as such have custody of the records of Ohio and Foreign business entities; that said records show MEDICAL SUPPLY DISTRIBUTION LLC, an Ohio For Profit Limited Liability Company, Registration Number 3960076, was organized within the State of Ohio on November 15, 2016, is currently in FULL FORCE AND EFFECT upon the records of this office.

Witness my hand and the seal of the Secretary of State at Columbus, Ohio this 30th day of April, A.D. 2018.

Jon Husted

Ohio Secretary of State

Validation Number: 201812002304



List of People that will be counting and handling pharmaceuticals on a daily basis Will be:

1. Matthew C. Brandt
2. Brittany M. Adams (Office Manager)

This will be for counting purposes for checks and balances

STATE OF OHIO
BOARD OF PHARMACY

LICENSE TO DISTRIBUTE DANGEROUS DRUGS

The entity named below is duly licensed, and is entitled to conduct business in the state of Ohio until June 30, 2021.

MEDICAL SUPPLY DISTRIBUTION, LLC

Medical Supply Distribution

2340 OLD ADAMSVILLE ROAD

ZANESVILLE, OH 43701

License Number: 012654400

Wholesaler - Category 3

Expiration Date: June 30, 2021

CLASS: Wholesaler - Category 3
BUSINESS TYPE: FS - Full Service

Responsible Person – Print, sign and keep license in a readily retrievable location at the address listed on this license.

Responsible Person Name (Print)	Signature of Responsible Person
MATTHEW BRANDT	

Any change of responsible person must be reported within ten days of the effective date of the appointment of the new responsible person via Service Request on your Ohio eLicense Dashboard - https://elicense.ohio.gov/oh_homepage.

State of Ohio Board of Pharmacy
77 South High Street, 17th Floor, Columbus, Ohio 43215
T: 614/466-4143 | F: 614/752-4836 | licensing@pharmacy.ohio.gov

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane
Reno, NV 89509
(775) 850-1440
Fax: (775) 850-1444

PHARMACEUTICAL WHOLESALER SURETY BOND

Bond No. 10098283

Application/License No. _____

Medical Supply Distribution, LLC (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is 2340 Adamsville Road Zanesville, OH 43701 (Address of Applicant/Principal), as PRINCIPAL, and Hudson Insurance Company (Surety Company), a corporation organized under the laws of the state of Delaware (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is 1035 Greenwood Blvd, Suite 265 Lake Mary, FL 32746 (Address of Surety) as SURETY, are held and firmly bound unto the State of Nevada and to the Nevada State Board of Pharmacy for the penal sum of ONE HUNDRED THOUSAND DOLLARS ($100,000.00), for which payment we bind ourselves, our heirs, executors, administrators, successors and assigns jointly and severally, by these presents. This bond term shall become effective on 10/3/2019 12:00:00 AM (Effective Date).

WHEREAS, the provisions of Nevada Revised Statutes (NRS) 639.515 require that the Applicant/Principal file or have on file with the Nevada State Board of Pharmacy (Board) a bond in the sum of $100,000.00 payable to the Nevada State Board of Pharmacy and this bond is executed and tendered in accordance therewith. This bond secures payment of any administrative fines imposed by the Board pursuant to NRS 639.255 and any costs incurred by the Board regarding the license of Applicant/Principal that are impose pursuant to NRS 622.400 or 622.410 which the Applicant/Principal fails to pay.

THIS BOND is subject to the following conditions:

(1) This bond shall be deemed continuous in form and shall remain in full force and effect and shall run concurrently with the license period for which the license is granted and each and every succeeding license period or periods for which said Applicant/Principal may be licensed, after which liability hereunder shall cease except as to any liability or indebtedness therefore incurred or accrued hereunder.
(2) This bond is executed by the Applicant/Principal and the Surety to comply with the provisions of NRS 639.515 and said bond shall be subject to all of the terms and provisions thereof.
(3) The Surety, its successors and assigns, are jointly and severally liable on the obligations of the bond.
(4) The limitations of the liability of the Surety and the conditions of the bond are set forth in NRS 639.515. Any claim by the Board may be made directly to the Surety and need not be preceded by the filing of any action in a proper court. Payment of any such claim shall be payable to the Nevada State Board of Pharmacy.
(5) The aggregate liability of the Surety hereunder on all claims whatsoever shall not exceed the penal sum of this bond in any event.
(6) This bond may not be cancelled by the Surety without first giving the Board written notice at least thirty days in advance of any intent to cancel the bond.
(7) The Applicant/Principal and Surety may be served with notices, papers and other documents at the addresses given above.

I certify or declare under penalty of perjury, under the laws of the State of Nevada, that I have executed the foregoing bond on behalf of the Surety under an unrevoked power of attorney.

In witness whereof, each party to this bond has caused it to be executed on this _____ day of _____, 20____.

APPLICANT/PRINCIPAL

_____
Authorized Representative

SURETY COMPANY

_____
Surety Company's Representative

Eric Fauerbach, Attorney-in-fact
print name

SIGNED and SEALED in the presence of:

_____
Witness

_____
Witness

SIGNED and SEALED in the presence of:

_____
Witness

_____
Witness

Countersigned by:

_____
Nevada Resident Agent

HUDSON INSURANCE GROUP

Bond Number: 10098283

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That HUDSON INSURANCE COMPANY, a corporation of the State of Delaware, with offices at 100 William Street, New York, New York, 10038, has made, constituted and appointed, and by these presents, does make, constitute and appoint

Eric Fauerbach

of the State of SC

its true and lawful Attorney(s)-in-Fact, at New York, New York, each of them alone to have full power to act without the other or others, to make, execute and deliver on its behalf, as Surety, bonds and undertakings given for any and all purposes, also to execute and deliver on its behalf as aforesaid renewals, extensions, agreements, waivers, consents or stipulations relating to such bonds or undertakings provided, however, that no single bond or undertaking shall obligate said Company for any portion of the penal sum thereof in excess of the sum of

One Hundred Thousand Dollars ($100,000.00)

Such bonds and undertakings when duly executed by said Attorney(s)-in-Fact, shall be binding upon said Company as fully and to the same extent as if signed by the President of said Company under its corporate seal attested by its Secretary.

In Witness Whereof, HUDSON INSURANCE COMPANY has caused these presents to be of its Senior Vice President thereunto duly authorized, on this 16th day of November, 20 17 at New York, New York.

(Corporate seal)

HUDSON INSURANCE COMPANY

Attest.....
Dina Daskalakis
Corporate Secretary

By.....
Michael P. Cifone
Senior Vice President

STATE OF NEW YORK
COUNTY OF NEW YORK. SS.

On the 16th day of November, 20 17 before me personally came Michael P. Cifone to me known, who being by me duly sworn did depose and say that he is a Senior Vice President of **HUDSON INSURANCE COMPANY**, the corporation described herein and which executed the above instrument, that he knows the seal of said Corporation, that the seal affixed to said instrument is such corporate seal, that it was so affixed by order of the Board of Directors of said Corporation, and that he signed his name thereto by like order.

(Notarial Seal)

ANN M. MURPHY
NOTARY PUBLIC
STATE OF NEW YORK

.....
ANN M. MURPHY
Notary Public, State of New York
No. 01MU6067553
Qualified in Nassau County
Commission Expires December 10, 2021

CERTIFICATION

STATE OF NEW YORK
COUNTY OF NEW YORK SS.:

The undersigned **Dina Daskalakis** hereby certifies:

That the original resolution, of which the following is a true and correct copy, was duly adopted by unanimous written consent of the Board of Directors of Hudson Insurance Company dated July 27th, 2007, and has not since been revoked, amended or modified:

"RESOLVED, that the President, the Executive Vice Presidents, the Senior Vice Presidents and the Vice Presidents shall have the authority and discretion, to appoint such agent or agents, or attorney or attorneys-in-fact, for the purpose of carrying on this Company's surety business, and to empower such agent or agents, or attorney or attorneys-in-fact, to execute and deliver, under this Company's seal or otherwise, bonds obligations, and recognizances, whether made by this Company as surety thereon or otherwise, indemnity contracts, contracts and certificates, and any and all other contracts and undertakings made in the course of this Company's surety business, and renewals, extensions, agreements, waivers, consents or stipulations regarding undertakings so made; and

FURTHER RESOVLED, that the signature of any such Officer of the Company and the Company's seal may be affixed by facsimile to any power of attorney or certification given for the execution of any bond, undertaking, recognizance, contract of indemnity or other written obligation in the nature thereof or related thereto, such signature and seal when so used whether heretofore or hereafter, being hereby adopted by the Company as the original signature of such officer and the original seal of the Company, to be valid and binding upon the Company with the same force and effect as though manually affixed."

THAT the above and foregoing is a full, true and correct copy of Power of Attorney issued by said Company, and of the whole of the original and that the said Power of Attorney is still in full force and effect and has not been revoked, and furthermore that the Resolution of the Board of Directors, set forth in the said Power of Attorney is now in force.

Witness the hand of the undersigned and the seal of said Corporation this 3rd day of October, 2019.

(Corporate seal)

By.....
Dina Daskalakis, Corporate Secretary