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*** _____

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: Alliance Medication Services LLC

Physical Address: 88 Mahanoy Ave. Tamaqua PA 18252

Mailing Address: PO BOX 222

City: Barnesville State: PA Zip Code: 18214

Telephone: 866-929-8590 Fax: 570-668-8825

Toll Free Number: 866-929-8590 (Required per NAC 639.708)

E-mail: rachael@alliancemeds.com Website: www.alliancemeds.com

Managing Pharmacist: Rachael Thorne License Number: RP443625

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☒	☐ Retail	☐	☒ Offsite 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: Workers' Compensation

****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

André S. Hinchman
Print Name of Authorized Person

2-6-20
Date

Board Use Only Date Processed: FEB 2 0 2020 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: Alliance Medication Services. LLC.

Mailing Address: P.O. Box 222

City: Barnesville State: PA Zip: 19426

Telephone: 570-668-8820 Fax: 570-668-8825

Contact Person: Andre' Hinchman CEO.

For any corporation non publicly traded, disclose the following:

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

a) Sue Mickatavage (Name) West Elm, Gordon PA 17936 (Address)

b) Colleen Fowler (Name) State Rd, Barnesville, PA 18214 (Address)

c) André Hinchman (Name) Meadowridge Cir, Collegeville PA 19426 (Address)

d) Ø (Name) (Address)

2) Provide the number of shares issued by the corporation. 567

3) What was the price paid per share? $ 52.91

4) What date did the corporation actually receive the cash assets? 24 NOV 2010

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

List any physician shareholders and percentage of ownership.

Name: Ø %:

Name: Ø %:

Hours of Operation for the pharmacy:

Monday thru Friday	9	am	5	pm	Saturday	N/A am	N/A 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

Alliance Medication Services, LLC Corporate Officers			
Name	Title	Address	DOB
Andre S. Hinchman	CEO and Managing Member	Meadowridge Circle, Collegeville, PA 19426	
Colleen M. Fowler	CFO	State Road, Barnesville, PA 18214	(
Susanne M. Mickatavage	COO	West Elm Street, Gordon, PA 17936	)
BUSINESS ADDRESS: P.O. Box 222, Barnesville,. PA 18214			
PHARMACY ADDRESS: 88 Mahanoy Avenue, Tamaqua, PA 18252			
CORPORATE NAME: Alliance Medication Services, D/B/A AllianceMeds, D/B/A MSA-Meds			

RECORD OF CERTIFICATES ISSUED AND TRANSFERRED

CERTIFICATES ISSUED		ISSUED TO (NAME AND ADDRESS)	DATE ISSUED	UNITS/PERCENTAGE TRANSFERRED FROM (IF ORIGINAL ISSUE ENTER AS SUCH)		AMOUNT PAID THEREON	RECEIVED CERTIFICATE				ENT ORIGI ISSU ONL
CERTIF NOS.	NO. UNITS			NAME	CERTIF NOS		DATE	SIGNATURE	DATE	NO UNITS	
1	184	Kristin Hinchman Cancelled	6/9/08	11/24/10		$10,000.00					
2	184	Susanne M Micheloud	6/9/08			$10,000.00					
3	184	Colleen M Foster	6/9/08			$10,000.00					
4		VOID									
5	15	David Cooper III	6/25/08	~~11/24/10~~ 18 Sept 2018							
6	184	Andre Hinchman	11/24/10								

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, André S. Hinchman CEO

Responsible Person of Alliance Medication Services, 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

André S. Hinchman — Print Name of Authorized Person

2-6-20 — Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Pa)
Schuylkill) ss.
COUNTY)

I, André Hinchman, 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 CEO for Alliance Medication Services 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, André S. Hinchman, 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
6th day of Feb, 2020

NOTARY PUBLIC

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Michelle D. Krell, Notary Public
Tamaqua Borc. Schuylkill County
My Commission Expires Jan. 6, 2021
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

773

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

Pharmacy

License Number
PP482133

Expiration Date
08/31/2021

Active

ALLIANCE MEDICATION SERVICES, LLC
RACHAEL ERIN THO
88 MAHANOY AVE
TAMAQUA, PA 18252

OFFICIAL DOCUMENT

Pennsylvania Licensing System (PALS)

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

ALLIANCE MEDICATION SERVICES, LLC
RACHAEL ERIN THO
88 MAHANOY AVE
TAMAQUA, PA 18252

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

19 0805996

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

License Type
Pharmacy

License Status
Active

ALLIANCE MEDICATION SERVICES, LLC
RACHAEL ERIN THORNE
88 MAHANOY AVE
TAMAQUA, PA 18252

Initial License Date
05/27/2011

Expiration Date
08/31/2021

License Number
PP482133

Acting Commissioner of Professional and Occupational Affairs

Signature

ALTERATION OF THIS DOCUMENT IS A CRIMINAL OFFENSE UNDER 18 PA C.S.S. 4911

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

02/12/2020

TO ALL WHOM THESE PRESENTS SHALL COME, GREETING:

I DO HEREBY CERTIFY THAT,

Alliance Medication Services LLC

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

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

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

Kathy Boockvar

Secretary of the Commonwealth

Certification Number: TSC200212090339-1

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

4B

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: ANGELS PHARMACY III LLC

Physical Address: 7455 US 1 STE A, Titusville, FL - 32780

Mailing Address: 7455 US 1 STE A

City: Titusville State: FL Zip Code: 32780

Telephone: 321-225-4833 Fax: 321-225-4559

Toll Free Number: 888-688-2643 (Required per NAC 639.708)

E-mail: Angelspharmacy3@gmail.com Website: _____

Managing Pharmacist: Parag Patel License Number: PS57572

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 <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.

H.J. Shah
Original Signature of Person Authorized to Submit Application, no copies or stamps

Hardik Shah
Print Name of Authorized Person

11/11/19
Date

Board Use Only Date Processed: 2-11-2020 Amount: 500-

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General _____ Limited ✓

Partnership Name: ANGELS PHARMACY III LLC

Mailing Address: 7455 US-1 STE A

City: Titusville State: FL Zip Code: 32780

Telephone Number: 321-225-4833 Fax Number: 321-225-4559

Contact Person: Pavey Patel

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
See Attachment.		

List names of 4 largest partners and percentage of ownership:

Name: Virat Patel %: 50

Name: Hardik Shah %: 25

Name: Pavey Patel %: 15

Name: Rajendra Patel %: 10

List any physician shareholders and percentage of ownership.

Name: -N/A- %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5 pm Saturday 10 am 1 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, Hawdik Shah

Responsible Person of Angels Pharmacy III 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.

H. g. Shah

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

Hawdik Shah

Print Name of Authorized Person

11/11/19

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Florida)
) ss.
Orange COUNTY)

I, Hardik Shah, 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 Angel's 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, Hardik Shah, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Alden Duhaney
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
21 day of January, 20 20

A. Duhaney
NOTARY PUBLIC

Notary Public State of Florida
Alden Duhaney
My Commission GG 266562
Expires 10/14/2022

AC#

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/09/2019	PH 31025	107461

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**

ANGELS PHARMACY III LLC
ANGEL'S PHARMACY
7455 US-1
SUITE A
TITUSVILLE, FL 32780

Ron DeSantis
GOVERNOR

DISPLAY IF REQUIRED BY LAW

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

AC#

DATE	LICENSE NO	CONTROL NO
01/09/2019	PH 31025	107461

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

ANGELS PHARMACY III LLC

LICENSEE SIGNATURE

QUALIFICATION(S):
Community Pharmacy
Schedule II & III

State of Florida
Department of State

I certify from the records of this office that ANGELS PHARMACY III LLC is a limited liability company organized under the laws of the State of Florida, filed on May 4, 2016.

The document number of this limited liability company is L16000088402.

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 30, 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-eighth day of January, 2020

Secretary of State

Tracking Number: 8271663894CU

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

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

Angel's Pharmacy
7455 S US Highway 1, Suite A, Titusville, FL 32780
Phone: 321-225-4833 Fax: 321-225-4559
Email: angelspharmacy3@gmail.com

Angels Pharmacy III LLC Ownership Detail:

Business Address: 7455 S US Hwy 1, Suite A, Titusville, FL 32780

1) Virat Patel – 50%
   Title: Owner
   DOB:
   Solar Dr, Winter Garden FL-34787
   Phone #
   SSN :
   Liability: Limited

2) Hardik Shah – 25%
   Title: Owner
   DOB:
   Dusty Pine Dr, Apopka, FL-32703
   Phone #
   SSN:
   Liability: Limited

3) Parag Patel – 15%
   Title: Owner, Pharmacist-In-Charge
   DOB:
   State Pharmacist Lic # FL - PS57572
   Dusty Pine Dr, Apopka, FL-32703
   Phone # 5
   SSN:
   Liability: Limited

4) Rajendra Patel – 10%
   Title: Owner
   DOB:
   Grand Avenue, Apt Pinellas Park, FL-33782
   Phone #
   SSN :
   Liability: Limited

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the Healthiest State in the Nation

January 13, 2020

Angel's Pharmacy
7455 US-1
Suite A
Titusville,FL 32780

RE: License Certification for Angels Pharmacy III 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:	PH31025
ORIGINAL CERTIFICATION:	11/07/2017
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,

Gerlisia K. Still
Regulatory Specialist II

/gs

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

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**)

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☐ *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 #1348

Physical Address: 260 Logistics Ave., Suite B, 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: Samuel Lee 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,**

The board has a legal right to require an appearance at a schedule board meeting. If an appearance is **required**, your company will be notified in writing two (2) weeks prior to the meeting.

If you check off-site cognitive services on the application, Nevada Administrative Code 639.4916 requires "A pharmacist who is employed by an off-site pharmaceutical service provide to provide remote chart order processing services to a hospital or correctional institution pursuant to NAC 639.4915 must (a) Be licensed to practice in Nevada." Provide name and Nevada pharmacist license number. This does not have to be the managing pharmacist.

A license is usually issued and mailed within 15 days from the board meeting date, if approved.

This license is renewed in October of even numbered years, no matter when the license is issued. Fees are not pro-rated.

Please access the applicable laws on the website under "Nevada Statues & Regulations" tab.

If you have any questions, contact the licensing specialist in the Reno office at (775) 850-1440 or by email at pharmacy@pharmacy.nv.gov.

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? OK for consent per Yenh 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.

Victor Curtis

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

Victor Curtis

Print Name of Authorized Person

12/12/19

Date

Board Use Only Date Processed: 2-5-2020 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.

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Indiana)
) ss.
Clark COUNTY)

I, Samuel Lee, 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 Pharmacy Manager for Costco Pharmacy #1348 (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, Samuel Lee, 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
11th day of Dec., 2019.

Cheryl Howell
NOTARY PUBLIC

CHERYL HOWELL
Notary Public, State of Indiana
Clark
Commission Number NP0716399
My Commission Expires
October 21 2026
SEAL
NOTARY PUBLIC
INDIANA

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Victor Curtis

Responsible Person of Costco Pharmacy #1348

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

12/12/19
Date

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

License Verifications

Regarding the pharmacy facility and pharmacist in charge license verification certification requirement. Costco Pharmacy #1348 is located in the State of Indiana. The Indiana Board of Pharmacy only provides electronic license verification certifications from their website and does mail hard copies.

Please contact me if you have any questions.

Kristopher Shearer
kshearer@costco.com

STATE OF INDIANA

Eric J. Holcomb

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE Costco Pharmacy #1348

I, Deborah J. Frye, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature.

To verify the authenticity of the digital certification as of the date and time stamp below, go to
https://secure.in.gov/apps/pla/search/verify/
and use our free web service. Simply browse to the location you saved the secure PDF document sent to you and upload to validate. You may also verify the authenticity in Adobe by ensuring the 'Certified by State of Indiana' blue ribbon displays at the top of the PDF.

Deborah J. Frye

Deborah J. Frye, Executive Director
Thu Jun 20 01:37:21 PM EST 2019

STATE OF INDIANA

Eric J. Holcomb

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Facility Name:	Costco Pharmacy #1348
Address:	260 Logistics Ave., Suite B Jeffersonville, IN 47111
Owner Name:	

License Information

Number Issued:	60006731A
License Type:	Pharmacy - Closed Door (III)
Status:	Active
Issue date:	06/17/2019
Expiration Date:	12/31/2019
Obtained By:	Application

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams

For disciplinary action information, please visit our License Search & Verify service at www in gov/pla/3119 htm Disciplinary action will either show under Previous Action or Violations. For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at http //www in gov/pla/boards htm.

Digitally Certified on: Thu Jun 20 01:37:21 PM EST 2019

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
60006731A	12/31/2021

Costco Wholesale Corporation d/b/a Costco Pharmacy #1348

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
60006731A	**12/31/2021**

Costco Wholesale Corporation d/b/a Costco Pharmacy #1348

Signature

4D

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: **Garfield Beach CVS, L.L.C. dba CVS/pharmacy # 11339**

Physical Address: **777 S. Harbor Blvd., Suite E-164, La Habra, CA 90631**

Mailing Address: **One CVS Dr, Licensing Dept/MC1160**

City: **Woonsocket** State: **RI** Zip Code: **02895**

Telephone: 866-735-6655 Fax: 401-765-7885

Toll Free Number: 866-735-6655 (Required per NAC 639.708)

E-mail: **PermitInfo@CVSHealth.com** Website: **www.cvs.com/content/multidose**

Managing Pharmacist: **Min G Oh** License Number: **CA Lic # 67873**

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 <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.

Kimberley DeSousa

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

Kimberley DeSousa, Assistant Secretary

Print Name of Authorized Person

6/5/19

Date

Board Use Only	Date Processed: 2-11-2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: RI 11/12/2004

Parent Company if any: CVS Pharmacy, Inc.

Mailing Address: One CVS Drive

City: Woonsocket State: RI Zip: 02895

Telephone: 401-765-1500 Fax: 401-765-7887

Contact Person: Therese Switzer, Lead Licensing Coordinator

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 - CVS Pharmacy, Inc. owns 100% of interest
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: N/A %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 9 pm Saturday 8 am 6 pm

Sunday 8 am 6 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

Garfield Beach CVS, L.L.C.
dba CVS/pharmacy #11339
777 S. Harbor Blvd., Suite E-164
La Habra, CA 90631

Personnel Name	Management Title	Home Address	Business Address	Phone
Thomas S. Moffatt	President	Homestead Circle, Kingston, RI 02881	One CVS Drive, Woonsocket, RI 02895	401-765-1500
Carol A. DeNale	Senior Vice President & Treasurer	Poplar St., Watertown, MA 02472	One CVS Drive, Woonsocket, RI 02895	401-765-1500
Melanie K. Luker	Secretary	Coldbrook Drive, Cranston, RI 02920	One CVS Drive, Woonsocket, RI 02895	401-765-1500
Jeffrey E. Clark	Assistant Treasurer	Joy Lane, Hingham, MA 02043	One CVS Drive, Woonsocket, RI 02895	401-765-1500
Sheelagh M. Beaulieu	Assistant Treasurer	Washington Street, Fairhaven, MA 02719	One CVS Drive, Woonsocket, RI 02895	401-765-1500
Linda M. Cimbron	Assistant Secretary	Bridge Street, Warren, RI 02885	One CVS Drive, Woonsocket, RI 02895	401-765-1500
Kimberley M. DeSousa	Assistant Secretary	Larchwood Dr, Cumberland 02864	One CVS Drive, Woonsocket, RI 02895	401-765-1500

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF California)
) ss.
Los Angeles COUNTY)

I, Min G Oh, 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 CVS/pharmacy # 11339 (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, Min G Oh, 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
8th day of May, 2019.

NOTARY PUBLIC

CAROLINE CHOO
Notary Public - California
Los Angeles County
Commission # 2165952
My Comm. Expires Sep 26, 2020

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, **Kimberley DeSousa, Assistant Secretary**

Responsible Person of **Garfield beach CVS, L.L.C. dba CVS/pharmacy # 11339**

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

Kimberley DeSousa, Assistant Secretary
Print Name of Authorized Person

6/5/19
Date

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME: GARFIELD BEACH CVS, L.L.C.

FILE NUMBER:	200432010237
FORMATION DATE:	11/12/2004
TYPE:	DOMESTIC LIMITED LIABILITY COMPANY
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 October 28, 2019.

ALEX PADILLA
Secretary of State

RML

NP-25 (REV 02/2019)

California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

November 19, 2019

CVS PHARMACY
ATTN: THERESE SWITZER
1 CVS DRIVE, MC 1160
WOONSOCKET, RI 02895

California State Board of Pharmacy License Verification

This document reflects the license status of the person or entity identified below on this date with the California State Board of Pharmacy. It may be used as prima facie evidence of the facts recited below pursuant to California Business and Professions Code section 162.

Licensee Name: CVS/PHARMACY # 11339

License Type: PHARMACY

License Number: PHY 57180

Status: ACTIVE

Issue Date: 10/23/19

Expiration Date: 06/01/20

Address of Record: 777 S HABOR BLVD STE E-164 LA HABRA CA 90631

Disciplinary Action: NO RECORD OF DISCIPLINARY ACTION

Anne Sodergren
Interim Executive Officer

By

Barbera Schleicher
Public Inquiry Analyst
(916) 518-3081
Barbera.Schleicher@dca.ca.gov

BOARD OF PHARMACY

LICENSING DETAILS FOR: PHY 57180

NAME: CVS/PHARMACY # 11339
LICENSE TYPE: PHARMACY (COMMUNITY)

LICENSE STATUS: CLEAR

ADDRESS
777 S HABOR BLVD STE E-164
LA HABRA CA 90631
ORANGE COUNTY

ISSUANCE DATE
OCTOBER 23, 2019

EXPIRATION DATE
JUNE 1, 2020

CURRENT DATE / TIME
OCTOBER 30, 2019
4:57:29 AM

LICENSE RELATIONSHIPS

NAME: OH, MIN GEE

LICENSE/REGISTRATION TYPE: REGISTERED PHARMACIST

LICENSE NUMBER: 67873 **PRIMARY STATUS:** CLEAR

Board of Pharmacy
1625 North Market Blvd.,
Suite N-219
Sacramento, CA 95834
916 574-7900

REGISTERED PHARMACIST

LICENSE NO. RPH 67873

EXPIRATION 02/29/20

MIN GEE OH
15818 MANDARIN LN
LA MIRADA CA 90638

Signature

RECEIPT NO.
80170811

4E

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: Equinox Home Care, Inc.

Physical Address: 2424 S. E. Bristol Street Suite 250 Newport Beach CA 92660

Mailing Address: 2424 S.E. Bristol Street, Suite 250

City: Newport Beach State: California Zip Code: 92660

Telephone: (949) 498-6284 Fax: N/A

Toll Free Number: 833-266-7462 (Required per NAC 639.708)

E-mail: gberman@equinoxus.com Website: www.equinoxus.com

Managing Pharmacist: N/A License Number: _____

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

****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

Gary Berman
Print Name of Authorized Person

12/20/19
Date

Board Use Only Date Processed: FEB 05 2020 Amount: 500.00

SEE CALIFORNIA JURAT ATTACHED DATE 12-20-19 INITL

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: Equinox Ophthalmic, Inc.

Mailing Address: 2424 S.E. Bristol Street, Suite 250

City: Newport Beach State: CA Zip: 92660

Telephone: (949) 498-6284 Fax: N/A

Contact Person: Gary Berman

For any corporation non publicly traded, disclose the following:

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

a) Gary Berman — 2424 S.E. Bristol Street, Suite 250, Newport Beach, California 92660
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: N/A %: _____

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: _____

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 20 day of December, 2019, by Gary Berman,
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

SARAH COOVER
COMM. # 2276155
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
MY COMM. EXP. JAN. 31, 2023

(Seal)

Signature

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Gary Berman, Chief Business Officer

Responsible Person of Equinox Home Care, 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

Gary Berman
Print Name of Authorized Person

12/20/19
Date

SEE CALIFORNIA ACKNOWLEDGMENT
INTL: DATE: 12-20-19

ACKNOWLEDGMENT

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)

On 12-20-2019 before me, Sarah Coover, Notary Public
(insert name and title of the officer)

personally appeared Gary Berman,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SARAH COOVER
COMM. # 2276155
NOTARY PUBLIC-CALIFORNIA
ORANGE COUNTY
MY COMM. EXP. JAN. 31, 2023

Signature _____ (Seal)

Equinox Home Care, Inc.

List of officers

John Berdahl- CEO

Matt Larson- COO/President

Gary Berman- Chief Business Officer

Michael W. Brown, Esq- Legal/Compliance Officer

TRAVELERS

One Tower Square, Hartford, Connecticut 06183

COMMON POLICY DECLARATIONS
OFFICE PAC
BUSINESS: OPTOMETRISTS

POLICY NO.: 680-0P098788-19-42
ISSUE DATE: 08/14/2019

INSURING COMPANY:
TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

1. **NAMED INSURED AND MAILING ADDRESS:**
   EQUINOX OPHTHALMIC INC
   EQUINOX HOME CARE INC
   4100 BIRCH ST
   STE 200
   NEWPORT BEACH CA 92660

2. **POLICY PERIOD:** From 07/30/2019 to 07/30/2020 12:01 A.M. Standard Time at your mailing address.

3. **DESCRIPTION OF PREMISES:**

PREM. LOC. NO.	BLDG. NO.	OCCUPANCY	ADDRESS (same as Mailing Address unless specified otherwise)
001	001	OPTOMETRISTS	4100 BIRCH ST STE 200 NEWPORT BEACH CA 92660

4. **COVERAGE PARTS AND SUPPLEMENTS FORMING PART OF THIS POLICY AND INSURING COMPANIES**

COVERAGE PARTS and SUPPLEMENTS	INSURING COMPANY
Businessowners Coverage Part	ACJ

5. The COMPLETE POLICY consists of this declarations and all other declarations, and the forms and endorsements for which symbol numbers are attached on a separate listing.

6. **SUPPLEMENTAL POLICIES:** Each of the following is a separate policy containing its complete provisions.

POLICY	POLICY NUMBER	INSURING COMPANY

DIRECT BILL

7. **PREMIUM SUMMARY:**

Provisional Premium	$	599.00
Due at Inception	$	
Due at Each	$	

NAME AND ADDRESS OF AGENT OR BROKER

MARSH & MCLENNAN AGCY TY334
PO BOX 5113

SIOUX FALLS SD 57117-5113

COUNTERSIGNED BY:

Authorized Representative

DATE: 08/14/2019

Office: MINNEAPOLIS MN DOWN

TRAVELERS

One Tower Square, Hartford, Connecticut 06183

BUSINESSOWNERS COVERAGE PART DECLARATIONS

OFFICE PAC

POLICY NO.: 680-0P098788-19-42
ISSUE DATE: 08/14/2019

INSURING COMPANY:
TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

POLICY PERIOD:
From 07-30-19 to 07-30-20 12:01 A.M. Standard Time at your mailing address

FORM OF BUSINESS: CORPORATION

COVERAGES AND LIMITS OF INSURANCE: Insurance applies only to an item for which a "limit" or the word "included" is shown.

COMMERCIAL GENERAL LIABILITY COVERAGE

OCCURRENCE FORM	LIMITS OF INSURANCE
General Aggregate (except Products-Completed Operations Limit)	$ 4,000,000
Products-completed Operations Aggregate Limit	$ 4,000,000
Personal and Advertising Injury Limit	$ 2,000,000
Each Occurrence Limit	$ 2,000,000
Damage to Premises Rented to You	$ 300,000
Medical Payments Limit (any one person)	$ 5,000

BUSINESSOWNERS PROPERTY COVERAGE

DEDUCTIBLE AMOUNT: Businessowners Property Coverage: $ 1,000 per occurrence.
Building Glass: $ 1,000 per occurrence.

BUSINESS INCOME/EXTRA EXPENSE LIMIT: Actual loss for 12 consecutive months

Period of Restoration-Time Period: Immediately

ADDITIONAL COVERAGE:
Fine Arts: $ 25,000

Other additional coverages apply and may be changed by an endorsement. Please read the policy.

SPECIAL PROVISIONS:

COMMERCIAL GENERAL LIABILITY COVERAGE IS SUBJECT TO A GENERAL AGGREGATE LIMIT

BUSINESSOWNERS PROPERTY COVERAGE

PREMISES LOCATION NO.: 001 **BUILDING NO. :** 001

COVERAGE		LIMIT OF INSURANCE	VALUATION	COINSURANCE	INFLATION GUARD
BUSINESS PERSONAL PROPERTY	$	10,000	RC*	N/A	3.0%

*Replacement Cost

COVERAGE EXTENSIONS:

Accounts Receivable	$	25,000
Valuable Papers	$	25,000

Other coverage extensions apply and may be changed by an endorsement. Please read the policy.

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 INCORPORATION OF "EQUINOX HOME CARE, INC.", FILED IN THIS OFFICE ON THE TENTH DAY OF APRIL, A.D. 2019, AT 8:55 O`CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

7368084 8100
SR# 20197734849

Authentication: 203866938
Date: 10-25-19

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

State of Delaware
Secretary of State
Division of Corporations
Delivered 08:55 PM 04/10/2019
FILED 08:55 PM 04/10/2019
SR 20192741201 - File Number 7368084

CERTIFICATE OF INCORPORATION
OF
EQUINOX HOME CARE, INC.

ARTICLE 1

The name of this corporation is Equinox Home Care, Inc.

ARTICLE 2

The address of the registered office of the Corporation in the State of Delaware is 1209 Orange Street, Wilmington, Delaware 19801, County of New Castle. The name of the Corporation's registered agent at that address is The Corporation Trust Company.

ARTICLE 3

The purpose of the Corporation is to engage in any lawful act or activity for which corporations may be organized under the General Corporation Law of the State of Delaware, as amended from time to time.

ARTICLE 4

The total number of shares of capital stock which this Corporation has authority to issue is 100 shares of Common Stock, $0.0001 par value per share.

ARTICLE 5

(a) The election of directors need not be by written ballot unless otherwise provided in the Bylaws. The number of directors of the Corporation will be as specified in the Corporation's Bylaws.

(b) Meetings of the stockholders may be held within or without the State of Delaware, as the Bylaws may provide. The books of the Corporation may be kept (subject to any provision contained in the General Corporation Law of the State of Delaware) outside the State of Delaware at such place or places as may be designated from time to time by the Board of Directors or by the Bylaws of the Corporation.

(c) The Corporation reserves the right to amend, alter or repeal in any respect any provision of the Certificate of Incorporation in the manner now or subsequently prescribed by statute, and all rights and powers conferred upon directors or stockholders in this Certificate of Incorporation or any amendment hereof are conferred subject to this reservation.

ARTICLE 6

(a) To the fullest extent permitted by applicable law, a director of this Corporation shall not be personally liable to the Corporation or its stockholders for monetary damages for any breach of fiduciary duty as a director.

(b) To the fullest extent permitted by applicable law, the Corporation may indemnify any person made or threatened to be made a party to any action or proceeding, whether criminal, civil, administrative or investigative, by reason of the fact that such person, or a person for whom such person is the legal representative, is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of any other enterprise.

(c) Any repeal or modification of this Article 6 by the stockholders of the Corporation shall be prospective only, and shall not eliminate or reduce the effect of this Article 6 in respect of any matter occurring, or any action or proceeding accruing or arising or that, but for this Article 6, would accrue or arise prior to such repeal or modification.

ARTICLE 7

The Board of Directors of the Corporation shall have the power to make, alter, amend or repeal the Bylaws of the Corporation, or adopt new Bylaws, without any action on the part of the stockholders.

ARTICLE 8

Unless the Corporation consents in writing to the selection of an alternative forum, to the fullest extent permitted by law, the sole and exclusive forum for (i) any derivative action or proceeding brought on behalf of the Corporation, (ii) any action asserting a claim of breach of a fiduciary duty owed by any director, officer, employee or agent of the Corporation to the Corporation or the Corporation's stockholders, (iii) any action asserting a claim arising pursuant to any provision of the General Corporation Law of the State of Delaware, or (iv) any action asserting a claim governed by the internal affairs doctrine, shall be the Court of Chancery of the State of Delaware, in all cases subject to such court having personal jurisdiction over the indispensable parties named as defendants.

ARTICLE 9

The name and address of the Incorporator of the Corporation is as follows:

Thomas Pascoe
660 Newport Center Drive, Suite 1600
Newport Beach, California 92660-6422

I, THE UNDERSIGNED, being the Incorporator, for the purpose of forming a corporation under the laws of the State of Delaware, do make, file and record this Certificate of Incorporation, do certify that the facts herein stated are true, and accordingly, have hereunto set my hand this 10th day of April, 2019.

/s/ Thomas Pascoe
Thomas Pascoe, Incorporator

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: FUSION RX PHARMACY

Physical Address: 3848 N TARRANT PKWY, STE 150, FORT WORTH, TX 76244

Mailing Address: 3848 N TARRANT PKWY, STE 150, FORT WORTH, TX 76244

City:_____ State:_____ Zip Code: _____

Telephone: (817) 562-7871 Fax: (817) 562-7872

Toll Free Number: (888) 982-9656 (Required per NAC 639.708)

E-mail: INFO@FUSIONRXPHARMACY.C Website: NONE

Managing Pharmacist: JENNIT RAJU License Number: 50740

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

SUNJAY WAGLE

Print Name of Authorized Person

01/25/2020

Date

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

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: TEXAS

Parent Company if any: FUSION RX SPECIALTY PHARMACY, LLC

Mailing Address: 3848 N TARRANT PKWY, STE 150

City: FORT WORTH State: TEXAS Zip: 76244

Telephone: (817) 562-7871 Fax: (817) 562-7872

Contact Person: SUNJAY WAGLE

For any corporation non publicly traded, disclose the following:

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

a) SUNJAY WAGLE - 3848 N TARRANT PKWY, STE 150, FORT WORTH, TX 76244
Name Address

b) CHETAN VAYANI - 3848 N TARRANT PKWY, STE 150, FORT WORTH, TX 76244
Name Address

c) JENNIT RAJU - 3848 N TARRANT PKWY, STE 150, FORT WORTH, TX 76244
Name Address

d) NIKHIL BHAYANI - 3848 N TARRANT PKWY, STE 150, FORT WORTH, TX 76244
Name Address

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

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5:30 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, SUNJAY WAGLE

Responsible Person of FUSION RX 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

SUNJAY WAGLE
Print Name of Authorized Person

01/25/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF TEXAS)
) ss.
DENTON COUNTY)

I, SUNJAY WAGLE, 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 OFFICER for FUSION RX 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, SUNJAY WAGLE, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

SUNJAY WAGLE
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
1st day of FEBRUARY, 2020.

NOTARY PUBLIC

OSMOND DAVIDSON
NOTARY PUBLIC
STATE OF TEXAS
NOTARY ID 132016789
MY COMM. EXP. 05-13-2023

TEXAS STATE BOARD OF PHARMACY

Re:	Jennit Raju, R.Ph.
License No.:	50740
Date Issued:	September 09, 2011
Licensure Status:	Active
Expiration Date:	August 31, 2020
Granted by:	Examination
Prior Disciplinary Orders:	No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. Jennit Raju, R.Ph. (Texas Pharmacist License #50740) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

Megan G. Holloway
Assistant General Counsel
Texas State Board of Pharmacy

January 22, 2020
Date


TEXAS STATE BOARD OF PHARMACY
License No.
50740
Expiration Date
8/31/2020
JENNIT RAJU
RAJU, JENNIT
REGISTERED PHARMACIST
Allison Vordenbaumen Benz, R.P
Executive Director/Secretary

TEXAS STATE BOARD OF PHARMACY

Re:	Fusion RX Pharmacy
Address:	3848 N Tarrant Pkwy Ste 150 Fort Worth, TX 76244
License No.:	32981
Date Issued:	November 07, 2019
Licensure Status:	Active
Expiration Date:	November 30, 2021
Type of Pharmacy:	Community – Class A
Prior Disciplinary Orders:	No

The Texas State Board of Pharmacy maintains records regarding licensure and disciplinary action against a licensee. Fusion RX Pharmacy (Texas Pharmacy License #32981) has not been subject to disciplinary action by the Texas State Board of Pharmacy.

Form Completed by:

Megan G. Holloway
Assistant General Counsel
Texas State Board of Pharmacy

January 22, 2020
Date

The Texas Department of State Health Services, Drugs and Medical Devices Division, Wholesaler Registration, 1100 W. 49th Street, Austin, TX 78756, is responsible for issuing registrations to wholesale drug distributors and drug manufacturers in Texas.

This certifies that the pharmacy named below is hereby licensed to operate as a Class A pharmacy.

License No. 32981 Expiration Date: 11/30/2021

Balances: 1

FUSION RX PHARMACY
3848 N TARRANT PKWY STE 150
FORT WORTH TX 76244

Allison Vordenbaumen Benz, R.Ph., M.S.
Executive Director/Secretary

MUST BE DISPLAYED IN FULL PUBLIC VIEW

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

Ruth R. Hughs
Secretary of State

Office of the Secretary of State

CERTIFICATE OF FILING
OF

Fusion RX Specialty Pharmacy LLC
803346206

The undersigned, as Secretary of State of Texas, hereby certifies that a Certificate of Amendment for the above named entity has been received in this office and has been found to conform to the applicable provisions of law.

ACCORDINGLY, the undersigned, as Secretary of State, and by virtue of the authority vested in the secretary by law, hereby issues this certificate evidencing filing effective on the date shown below.

Dated: 09/04/2019

Effective: 09/04/2019

Ruth R. Hughs
Secretary of State

FILED
In the Office of the
Secretary of State of Texas
SEP 04 2019
Corporations Section

CERTIFICATE OF AMENDMENT TO THE CERTIFICATE OF FORMATION OF FUSION RX SPECIALTY PHARMACY LLC A LIMITED LIABILITY COMPANY

This certificate of amendment is submitted for filing pursuant to the applicable provisions of the Texas Business Organizations Code.

Article I - Entity Name and Type

The name of the entity as shown in the records of the secretary of state and the type of filing entity are: Fusion RX Specialty Pharmacy LLC, a Texas limited liability company (hereinafter "Company"). The Company's date of formation is June 18, 2019, and its assigned file number is 803346206.

Article II - Other Amendments to Certificate of Formation

Set forth below is an identification by reference or description of each added, altered, or deleted provision.

1. The certificate of formation is amended by the alteration of the provisions identified or referenced below. A full text version of each altered provision so identified or referenced follows:

Article 3 - Governing Authority - The limited liability company is to be managed by managers. The name and addresses of the governing persons are set forth as follows:

Chet Vayani - PO Box 1986, Frisco, Texas 75034

Sunjay Wagle - PO Box 1986, Frisco, Texas 75034

Article III - Approval of Amendments

This filing amending the certificate of formation has been approved in the manner required by the Code and by the governing documents of the Company.

Article IV - Effective Date of Filing

This certificate of formation becomes effective when the document is filed by the secretary of state.

Article V - Execution

The undersigned signs this document subject to the penalties imposed by law for the

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

Jose A. Esparza
Deputy Secretary of State

Office of the Secretary of State

CERTIFICATE OF FILING
OF

Fusion RX Specialty Pharmacy LLC
File Number: 803346206

The undersigned, as Deputy Secretary of State of Texas, hereby certifies that a Certificate of Formation for the above named Domestic Limited Liability Company (LLC) has been received in this office and has been found to conform to the applicable provisions of law.

ACCORDINGLY, the undersigned, as Deputy Secretary of State, and by virtue of the authority vested in the secretary by law, hereby issues this certificate evidencing filing effective on the date shown below.

The issuance of this certificate does not authorize the use of a name in this state in violation of the rights of another under the federal Trademark Act of 1946, the Texas trademark law, the Assumed Business or Professional Name Act, or the common law.

Dated: 06/18/2019

Effective: 06/18/2019

Jose A. Esparza
Deputy Secretary of State

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

Filing Fee: $300

Certificate of Formation
Limited Liability Company

Filed in the Office of the Secretary of State of Texas
Filing #: 803346206 06/18/2019
Document #: 896169390002
Image Generated Electronically for Web Filing

Article 1 - Entity Name and Type

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

Fusion RX Specialty Pharmacy LLC

Article 2 – Registered Agent and Registered Office

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

OR

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

Name:
Milton W. Colegrove Jr

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

Street Address:
2340 E. Trinity Mills Rd.
Ste. 233 Carrollton TX 75006

Consent of Registered Agent

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

OR

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

Article 3 - Governing Authority

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

OR

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

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

Managing Member 1: (Business Name) **Crisp Investments LLC**

Address: **PO Box 1986 Frisco TX, USA 75034**

Managing Member 2. (Business Name) **Mantra LLC**

Address: **PO Box 1986 Frisco TX, USA 75034**

Managing Member 3: (Business Name) **Kingdom Seven Holdings, LLC**

Address: **PO Box 1986 Frisco TX, USA 75034**

Managing Member 4: (Business Name) **Ashrina LLC**

Address: **PO Box 1986 Frisco TX, USA 75034**

Article 4 - Purpose

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

Supplemental Provisions / Information

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

Organizer

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

Milton W. Colegrove Jr. **2340 E. Trinity Mills Rd., Ste. 233, Carrollton, Texas 75006**

Effectiveness of Filing

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

OR

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

Execution

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

Milton W. Colegrove Jr.

Signature of Organizer

FILING OFFICE COPY

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

Jose A. Esparza
Deputy Secretary of State

Office of the Secretary of State

CERTIFICATE OF FILING
OF

Fusion RX Specialty Pharmacy LLC
File Number: 803346206
Assumed Name:
Fusion RX Pharmacy

The undersigned, as Deputy Secretary of State of Texas, hereby certifies that the assumed name certificate for the above named entity has been received in this office and filed as provided by law on the date shown below.

ACCORDINGLY the undersigned, as Deputy Secretary of State, and by virtue of the authority vested in the secretary by law hereby issues this Certificate of Filing.

Dated: 08/15/2019

Effective: 08/15/2019

Jose A. Esparza
Deputy Secretary of State

Office of the Secretary of State
Corporations Section
P.O. Box 13697
Austin, Texas 78711-3697
(Form 503)

Filed in the Office of the
Secretary of State of Texas
Filing #: 803346206 8/15/2019
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ASSUMED NAME CERTIFICATE
FOR FILING WITH THE SECRETARY OF STATE

1. The assumed name under which the business or professional service is or is to be conducted or rendered is:

Fusion RX Pharmacy

2. The name of the entity as stated in its certificate of formation, application for registration, or comparable document is:

Fusion RX Specialty Pharmacy LLC

3. The state, country, or other jurisdiction under the laws of which it was incorporated, organized or associated is **TEXAS** and the address of its registered or similar office in that jurisdiction is:
2340 E. Trinity Mills Rd., Ste. 233, Carrollton, TX, USA 75006

4. The period, not to exceed 10 years, during which the assumed name will be used is : **10 year(s)**

5. The entity is a : **Domestic Limited Liability Company (LLC)**

6. The entity's principal office address is:

2340 E. Trinity Mills Rd., Ste. 233, Carrollton, TX, USA 75006

7. The entity is not organized under the laws of Texas and is not required by law to maintain a registered agent and registered office in Texas. Its office address outside the state is:

8. The county or counties where business or professional services are being or are to be conducted or rendered under such assumed name are:

ALL COUNTIES

9. The undersigned, if acting in the capacity of an attorney-in-fact of the entity, certifies that the entity has duly authorized the attorney-in-fact in writing to execute this document. The undersigned signs this document subject to the penalties imposed by law for the submission of a materially false or fraudulent instrument.

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

Jose A. Esparza
Deputy Secretary of State

Office of the Secretary of State

August 15, 2019

Milton W. Colegrove

Milton W. Colegrove
1 E. Trinity Mills Rd., Ste. 1
Carrollton, TX 75006 USA

RE: Fusion RX Specialty Pharmacy LLC
File Number: 803346206

Assumed Name:
Fusion RX Pharmacy

File Date: 08/15/2019

It has been our pleasure to file the assumed name certificate for the above referenced entity. Enclosed is the certificate evidencing filing. Payment of the filing fee is acknowledged by this letter.

In addition to filing with the Secretary of State, Chapter 71 of the Texas Business and Commerce Code requires filing of the assumed name certificate with the county clerk in the county in which the principal office of the entity is located. If the entity is required by law to maintain a registered office address in Texas and its principal office address is not located in Texas, the assumed name certificate is required to be filed in the county in which the registered office address is located. If the entity is not required by law to maintain a registered office address, please refer to Section 71.103 of the Texas Business and Commerce Code for the appropriate place of filing.

If we can be of further service at any time, please let us know

Sincerely,

Corporations Section
Business & Public Filings Division

Enclosure

Fusion RX Specialty Pharmacy LLC

Name of the entity

By: Jennit Raju

Signature of officer, general partner, manager, representative or attorney-in-fact of the entity

FILING OFFICE COPY

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

Ruth R. Hughs
Secretary of State

Office of the Secretary of State

Certificate of Fact

The undersigned, as Secretary of State of Texas, does hereby certify that the document, Certificate of Formation for Fusion RX Specialty Pharmacy LLC (file number 803346206), a Domestic Limited Liability Company (LLC), was filed in this office on June 18, 2019.

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

In testimony whereof, I have hereunto signed my name officially and caused to be impressed hereon the Seal of State at my office in Austin, Texas on January 27, 2020.

Ruth R. Hughs
Secretary of State

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*
☐ *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: HILL DERM PHARMACY INC

Physical Address: 3065 S. HELLONVILLE AVE. Suite B

Mailing Address: 3065 S. HELLONVILLE AVE

City: SANFORD State: FL Zip Code: 32773

Telephone: 407 585 6060 Fax: 407 585 6065

Toll Free Number: 877-727-9579 (Required per NAC 639.708)

E-mail: elaine.kania-@hillderm PHARMACY.com Website: WWW.HILLDERMPHARMACY.COM

Managing Pharmacist: KAMINI PATEL License Number: PS 36210

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

KAMINI PATEL
Print Name of Authorized Person

2/4/2020
Date

Board Use Only Date Processed: 2-11-2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: FLORIDA

Parent Company if any: _____

Mailing Address: 3065 S. HELLONVILLE AVE

City: SANFORD State: FL Zip: 32773

Telephone: 407-585-6060 Fax: 407-585-6065

Contact Person: KAMINI PATEL

For any corporation non publicly traded, disclose the following:

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

a) JERRY S. ROTH (Name) 9 ALAQUA, LONGWOOD, FL 32812 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. NONE-

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: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 12 am 7 pm Saturday Closed am _____ 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: _____

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: Jerry Roth

Business Name: Hill Derm Pharmacy Inc.

Current Business Address: 3065 S. Mellonville Avenue

City: Sanford State: FL Zip Code: 32773

Telephone: 407-585-6060 Fax: 407-585-6065

List any physician shareholders and percentage of ownership.

Name: N/A %:

Name: %:

Name: %:

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday 12 pm 7 pm Saturday closed am 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:

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, KAMINI PATEL

Responsible Person of HILL DERM PHARMACY 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

KAMINI PATEL
Print Name of Authorized Person

2/4/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Florida)
) ss.
Seminole COUNTY)

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

1. I am the Managing Pharmacist for Hill Dorn 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, Kamini Patel, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

María Elena Darnell
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
4th day of February, 2020.

María Elena Darnell
NOTARY PUBLIC

MARIA ELENA DARNELL
Notary Public - State of Florida
Commission # GG 003050
My Comm. Expires Oct 12, 2020

State of Florida
Department of State

I certify from the records of this office that HILL DERM PHARMACY, INC. is a corporation organized under the laws of the State of Florida, filed on November 9, 2018, effective November 9, 2018.

The document number of this corporation is P18000093293.

I further certify that said corporation has paid all fees due this office through December 31, 2020, that its most recent annual report/uniform business report was filed on January 21, 2020, and that its status is active.

I further certify that said corporation has not filed Articles of Dissolution.

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

Secretary of State

Tracking Number: 5826684059CC

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

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

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

January 30, 2020

HILL DERM PHARMACY, INC
Elaine Kania
3065 S. Mellonville Ave. Ste B
Sanford, FL 32773

RE: License Certification for Hill Derm Pharmacy, Inc

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:	PH31964
ORIGINAL CERTIFICATION:	03/21/2019
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,

Lucy Nova

Lucy Nova
Regulatory Specialist II

/ln

GREAT SEAL OF THE STATE OF FLORIDA · IN GOD WE TRUST ·

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

HILL DERM PHARMACY, Inc.

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy., Suite 206
Reno, NV 89521

Officers & Directors

Owner 100%	Jerry S. Roth
Home Address	Alaqua, Longwood, FL 32779
Home Phone	
Business Address	3065 S. Mellonville Ave., Sanford, FL 32773
Business Phone	407 323 1887
Email Jerry Roth	jrhusky6@gmail.com

AC# 8889640

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
03/22/2019	PH 31964	114767

THE PHARMACY

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

QUALIFICATION(S):
Community Pharmacy

Expiration Date: FEBRUARY 28, 2021
HILL DERM PHARMACY, INC
3065 S. MELLONVILLE AVE
SUITE B
SANFORD, FL , 32773

Rod DeSantis
GOVERNOR

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: FEBRUARY 28, 2021

Your license number is PH 31964. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please visit www.FLHealthSource.gov and click "Renew A License" to renew online.

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

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*
☒ *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: HOMECARE RX INC

Physical Address: 695 US HWY 46, SUITE 100, FAIRFIELD, NJ 07004

Mailing Address: PO BOX 2397

City: SECAUCUS State: NJ Zip Code: 07096

Telephone: (877) 920-2090 Fax: (877) 920-0466

Toll Free Number: (877) 920-2090 (Required per NAC 639.708)

E-mail: dpatel@homecarerx.com Website: N/A

Managing Pharmacist: Ami Patel, R.Ph. License Number: 28RI03544600

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

DHARA PATEL
Print Name of Authorized Person

2/11/2020
Date

Board Use Only Date Processed: FEB 13 2020 Amount: 300.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: NEW JERSEY

Parent Company if any: INFUCARE RX INC

Mailing Address: PO BOX 2578

City: SECAUCUS State: NJ Zip: 07096

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

Contact Person: DHARA PATEL

For any corporation non publicly traded, disclose the following:

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

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

b) List of Officers appears on following page
Name Address

c) _____
Name Address

d) _____
Name Address

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

3) What was the price paid per share? $1

4) What date did the corporation actually receive the cash assets? 02/06/2015

5) Provide a copy of the corporation's stock register evidencing the above information - See Exhibit A

List any physician shareholders and percentage of ownership.

Name: NONE %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 5:30 pm Saturday Closed am _____ pm

Sunday Closed am _____ pm 24 Hours NO

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

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

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

List of officers and directors

DHARA PATEL, PRESIDENT/VICE-PRESIDENT/SECRETARY

SAJAL K. ROY, PHARM.D., VICE-PRESIDENT OF OPERATIONS

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, DHARA PATEL

Responsible Person of HOMECARE 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.

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

DHARA PATEL
Print Name of Authorized Person

2/11/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF NEW JERSEY)
) ss.
ESSEX COUNTY)

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

1. I am the PRESIDENT for HOMECARE RX 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, DHARA PATEL, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name DHARA PATEL

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

NOTARY PUBLIC

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

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF REVENUE AND ENTERPRISE SERVICES
SHORT FORM STANDING

HOMECARE RX INC
0400722426

I, the Treasurer of the State of New Jersey, do hereby certify that the above-named New Jersey Domestic For-Profit Corporation was registered by this office on February 06, 2015.

As of the date of this certificate, said business continues as an active business in good standing in the State of New Jersey, and its Annual Reports are current.

I further certify that the registered agent and office are:

DHARA PATEL
818 B 7TH ST,
SECAUCUS, NJ 07094

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my Official Seal at Trenton, this 26th day of December, 2019

Elizabeth Maher Muoio
State Treasurer

Certificate Number : 6103556463

Verify this certificate online at

https://www1.state.nj.us/TYTR_StandingCert/JSP/Verify_Cert.jsp

150

RECORD OF CERTIFICATES ISSUED AND TRANSFERRED

CERTIFICATES ISSUED		ISSUED TO (NAME AND ADDRESS)	DATE ISSUED	SHARES TRANSFERRED FROM (IF ORIGINAL ISSUE ENTER AS SUCH)		AMOUNT PAID THEREON	RECEIVED CERTIFICATE				ENTER ORIGINAL ISSUES ONLY
CERTIF. NOS.	NO. SHARES			NAME	CERTIF. NOS.		DATE	SIGNATURE	DATE	NO. SHARES	
1	600	DHARA PATEL	2/6/15			$1.00	2/6/15	Dhara Patel			
2	400	TRUPTI PATEL	2/6/15			$1.00	2/6/15	Trupti Patel			
3	400	DHARA PATEL	12/1/16	TRUPTI PATEL	2	$1.00	12/1/16	Dhara Patel			
4	1000	INFUCARE Rx INC.	11/28/18	DHARA PATEL	1 & 3	$1.00	11/28/18	Dhara Patel			

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
(775) 850-1440
985 DAMONTE RANCH PARKWAY, SUITE 206, RENO, NV 89521
LICENSE VERIFICATION

Name: HOMECARE RX INC
Address: 695 US HWY 46, SUITE 100
City: FAIRFIELD State: NJ Zip: 07004

I hereby authorize the NEW JERSEY BOARD OF PHARMACY to furnish to the Nevada State Board of Pharmacy, the information requested below.

Signature of Applicant [signature]

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
28RS00737900	Active	4/15/2015	6/30/2020

Has this license been encumbered in any way?	Type of Encumbrance: (if any
☐ Yes ☑ No	☐ Revoked ☐ Surrendered ☐ Limited N/A ☐ 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
[signature]	Agency Services Representative	NJ	2/11/2020	

2/11/2020

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: Jewel Pharmacy RX Corp dba Jewel Pharmacy

Physical Address: 51 E. Burlington St., STE C

Mailing Address: 51 E. Burlington St., STE C

City: Riverside State: Illinois Zip Code: 60546

Telephone: 888-316-3652 Fax: 708-438-4640

Toll Free Number: 888-316-3652 (Required per NAC 639.708)

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

Managing Pharmacist: Dipa V. Shah License Number: 051.298427

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

Daniel Lee
Print Name of Authorized Person

12-26-19
Date

Board Use Only	Date Processed: FEB 05 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Illinois

Parent Company if any: _____

Mailing Address: 51 E. Burlington St., STE C

City: Riverside State: IL Zip: 60546

Telephone: 888-316-3652 Fax: 708-438-4640

Contact Person: Daniel Lee

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 Lee (Name) Walnut Cir Porter Ranch CA 91326 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. 1500

3) What was the price paid per share? 15.00

4) What date did the corporation actually receive the cash assets? 09/24/2018

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 9 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: N/A

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Daniel Lee

Responsible Person of Jewel Pharmacy RX Corp dba Jewel 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

Daniel Lee
Print Name of Authorized Person

12-26-19
Date

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.

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF California)
) ss.
Los Angeles COUNTY)

I, Daniel Lee, 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 Jewel Pharmacy RX Corp dba Jewel 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, Daniel Lee, 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
26th day of December, 2019.

NOTARY PUBLIC

SUE I. HWANG
Notary Public - California
Los Angeles County
Commission # 2312542
My Comm. Expires Nov 15, 2023

FORM **BCA 2.10**
ARTICLES OF INCORPORATION
Business Corporation Act

Filing Fee: $150
Franchise Tax: $ 25
Total: $175

File #: **71992926**

Approved By: JXR

FILED
SEP 24 2018
Jesse White
Secretary of State

1. Corporate Name: JEWEL PHARMACY RX CORP.

2. Initial Registered Agent: LEGALINC CORPORATE SERVICES INC.
(First Name / Middle Initial / Last Name)

Initial Registered Office: E RANDOLPH ST STE
(Number / Street / Suite No.)

CHICAGO (City) IL 60601-6528 (ZIP Code) COOK (County)

3. Purposes for which the Corporation is Organized:
The transaction of any or all lawful businesses for which corporations may be incorporated under the Illinois Business Corporation Act.

4. Authorized Shares, Issued Shares and Consideration Received:

Class	Number of Shares Authorized	Number of Shares Proposed to be Issued	Consideration to be Received Therefor
COMMON	1500	1500	$ 15

NAME & ADDRESS OF INCORPORATOR

5. The undersigned incorporator hereby declares, under penalties of perjury, that the statements made in the foregoing Articles of Incorporation are true.

Dated SEPTEMBER 24 (Month & Day), 2018 (Year)

MARSHA SIHA (Name) — STATE HWY 249 (Street)

HOUSTON (City/Town) TX (State) 77064 (ZIP Code)

List of Owners:

Daniel Lee
Walnut Cir
Porter Ranch CA 91326

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO
054.021131
051.293312

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
03/31/2020

LICENSED PHARMACY

COMMUNITY

JEWEL PHARMACY RX CORP
DBA JEWEL PHARMACY
SHADI SALAMI
51 E BURLINGTON ST STE C
RIVERSIDE, IL 60546-2124

DEBORAH HAGAN
ACTING SECRETARY

JESSICA BAER
DIRECTOR

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

13659112

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: 4222074

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO
320.012943
054.021131

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
03/31/2020

LICENSED CONTROLLED SUBSTANCE

II III IV V

JEWEL PHARMACY RX CORP
DBA JEWEL PHARMACY
51 E BURLINGTON ST STE C
RIVERSIDE, IL 60546-2124

DEBORAH HAGAN
ACTING SECRETARY

JESSICA BAER
DIRECTOR

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

13659113

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: 4222074

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
051.298427

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:
03/31/2020

REGISTERED PHARMACIST

DIPA V DENOUDEN
N WEST ST
NAPERVILLE, IL 60563-2428

DEBORAH HAGAN
SECRETARY

CECILIA ABUNDIS
ACTING DIRECTOR

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

12217380

Cut on Dotted Line

Pharmacist-in-Charge
(Formerly Dipa V. Shah)

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: 1319069

Cut on Dotted Line

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

DBA Jewel Pharmacy
DIPA V DENOUDEN
51 E Burlington St Ste C

Licensee: License	Jewel Pharmacy Rx Corp
Number:	054.021131
Profession:	LICENSED PHARMACY
Date of Issuance:	03/20/2019
Expiration Date:	03/31/2020
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 01/08/2020

Cecilia Abundis
Acting Director
Division of Professional Regulation

01/08/2020
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

4J

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: Jewel Pharmacy RX Corp dba Jewel Pharmacy

Physical Address: 51 E. Burlington St., STE C

Mailing Address: 51 E. Burlington St., STE C

City: Riverside State: Illinois Zip Code: 60546

Telephone: 888-316-3652 Fax: 708-438-4640

Toll Free Number: 888-316-3652 (Required per NAC 639.708)

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

Managing Pharmacist: Dipa V. Shah License Number: 051.298427

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

Daniel Lee
Print Name of Authorized Person

12-26-19
Date

Board Use Only Date Processed: FEB 0 5 2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Illinois

Parent Company if any: _____

Mailing Address: 51 E. Burlington St., STE C

City: Riverside State: IL Zip: 60546

Telephone: 888-316-3652 Fax: 708-438-4640

Contact Person: Daniel Lee

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 Lee (Name) Walnut Cir Porter Ranch CA 91326 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

2) Provide the number of shares issued by the corporation. 1500

3) What was the price paid per share? 15.00

4) What date did the corporation actually receive the cash assets? 09/24/2018

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 9 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: N/A

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Daniel Lee

Responsible Person of Jewel Pharmacy RX Corp dba Jewel 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

Daniel Lee
Print Name of Authorized Person

12-20-19
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF California)
) ss.
Los Angeles COUNTY)

I, Daniel Lee, 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 Jewel Pharmacy RX Corp dba Jewel 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, Daniel Lee, 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
26th day of December, 2019.

NOTARY PUBLIC

SUE I. HWANG
Notary Public - California
Los Angeles County
Commission # 2312542
My Comm. Expires Nov 15, 2023

FORM **BCA 2.10**
ARTICLES OF INCORPORATION
Business Corporation Act

Filing Fee: $150
Franchise Tax: $ 25
Total: $175

File #: **71992926**

Approved By: JXR

FILED
SEP 24 2018
Jesse White
Secretary of State

1. Corporate Name: JEWEL PHARMACY RX CORP.

2. Initial Registered Agent: LEGALINC CORPORATE SERVICES INC.
(First Name / Middle Initial / Last Name)

Initial Registered Office: E RANDOLPH ST STE
(Number / Street / Suite No.)

CHICAGO (City) IL 60601-6528 (ZIP Code) COOK (County)

3. Purposes for which the Corporation is Organized:
The transaction of any or all lawful businesses for which corporations may be incorporated under the Illinois Business Corporation Act.

4. Authorized Shares, Issued Shares and Consideration Received:

Class	Number of Shares Authorized	Number of Shares Proposed to be Issued	Consideration to be Received Therefor
COMMON	1500	1500	$ 15

NAME & ADDRESS OF INCORPORATOR

5. The undersigned incorporator hereby declares, under penalties of perjury, that the statements made in the foregoing Articles of Incorporation are true.

Dated SEPTEMBER 24 (Month & Day), 2018 (Year)

STATE HWY 249 (Street)

MARSHA SIHA (Name)

HOUSTON (City/Town) TX (State) 77064 (ZIP Code)

List of Owners:

Daniel Lee
Walnut Cir
Porter Ranch CA 91326

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO
054.021131
051.293312

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
03/31/2020

LICENSED PHARMACY

COMMUNITY

JEWEL PHARMACY RX CORP
DBA JEWEL PHARMACY
SHADI SALAMI
51 E BURLINGTON ST STE C
RIVERSIDE, IL 60546-2124

DEBORAH HAGAN
ACTING SECRETARY

JESSICA BAER
DIRECTOR

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

13659112

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: 4222074

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO
320.012943
054.021131

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
03/31/2020

LICENSED CONTROLLED SUBSTANCE

II III IV V

JEWEL PHARMACY RX CORP
DBA JEWEL PHARMACY
51 E BURLINGTON ST STE C
RIVERSIDE, IL 60546-2124

DEBORAH HAGAN
ACTING SECRETARY

JESSICA BAER
DIRECTOR

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

13659113

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: 4222074

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
051.298427

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:
03/31/2020

REGISTERED PHARMACIST

DIPA V DENOUDEN
N WEST ST
NAPERVILLE, IL 60563-2428

DEBORAH HAGAN
SECRETARY

CECILIA ABUNDIS
ACTING DIRECTOR

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

12217360

Cut on Dotted Line

Pharmacist-in-Charge
(Formerly Dipa V. Shah)

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: 1319069

Cut on Dotted Line

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

DBA Jewel Pharmacy
DIPA V DENOUDEN
51 E Burlington St Ste C

Licensee: License	Jewel Pharmacy Rx Corp
Number:	054.021131
Profession:	LICENSED PHARMACY
Date of Issuance:	03/20/2019
Expiration Date:	03/31/2020
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 01/08/2020

Cecilia Abundis
Acting Director
Division of Professional Regulation

01/08/2020
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

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:* PH02929

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: Meridian Meds, LLC

Physical Address: 220 North 1200 East, Ste 104

Mailing Address: 220 North 1200 East, Ste 104

City: Lehi State: UT Zip Code: 84043

Telephone: 801-331-8291 Fax: 801-331-8650

Toll Free Number: 877-760-5223 (Required per NAC 639.708)

E-mail: brett.johnson@m2rx.com Website: www.m2rx.com

Managing Pharmacist: Brett C. Johnson License Number: 146323-1701

TYPE OF PHARMACY		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

Brett C. Johnson
Print Name of Authorized Person

2/13/2020
Date

Board Use Only Date Processed: FEB 2 0 2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP General N/A Limited N/A

Meridian Meds is a member managed LLC, not a Partnership. Therefore, Meridian Meds does not have general or limited partners. Meridian Meds has a sole member, which is Meridian Executive Group LLC.

Partnership Name: Meridian Executive Group LLC

Mailing Address: 1443 West 800 North, Ste. 103

City: Orem State: Utah Zip Code: 84057

Telephone Number: 801-655-4950 Fax Number: 801-655-4954

Contact Person: Richard Slack - Chief Executive Officer

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
Meridian Executive Group LLC - Sole Member of Meridian Meds LLC		

List names of 4 largest partners and percentage of ownership:

Name: N/A %:

Name: %:

Name: %:

Name: %:

List any physician shareholders and percentage of ownership.

Name: N/A %:

Name: %:

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday 8:30 am 4:30 pm Saturday N/A am N/A pm

Sunday N/A am N/A pm 24 Hours Yes - On Call 24/7

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, Brett C. Johnson

Responsible Person of Meridian Meds, 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

Brett C. Johnson
Print Name of Authorized Person

2/13/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF Utah)
) ss.
Utah County COUNTY)

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

1. I am the Managing Pharmacist/ Pharmacist-in-Charge for Meridian Meds, 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, Brett C. Johnson, 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
13th day of February, 2020.

NOTARY PUBLIC

NOTARY PUBLIC
JAYDEN EPPERSON
COMMISSION EXPIRES
JUNE 6, 2020
STATE OF UTAH

Certificate of Corporate Status

Utah Department of Commerce
Division of Corporations & Commercial Code
160 East 300 South, 2nd Floor, PO Box 146705
Salt Lake City, UT 84114-6705
Service Center: (801) 530-4849
Toll Free: (877) 526-3994 Utah Residents
Fax: (801) 530-6438
Web Site: http://www.commerce.utah.gov

02/12/2020
8315514-016002122020-1288551

CERTIFICATE OF EXISTENCE

Registration Number:	8315514-0160
Business Name:	MERIDIAN MEDS, LLC
Registered Date:	May 03, 2012
Entity Type:	LLC - Domestic
Status:	Current

The Division of Corporations and Commercial Code of the State of Utah, custodian of the records of business registrations, certifies that the business entity on this certificate is authorized to transact business and was duly registered under the laws of the State of Utah. The Division also certifies that this entity has paid all fees and penalties owed to this state; its most recent annual report has been filed by the Division (unless Delinquent); and, that Articles of Dissolution have not been filed.

Jason Sterzer
Director
Division of Corporations and Commercial Code

Letter of Good Standing

State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

GARY R. HERBERT
Governor

FRANCINE A. GIANI
Executive Director

MARK B. STEINAGEL
Division Director

VERIFICATION OF UTAH LICENSURE

Created On: 02/12/2020

This verification is considered a primary source from the State of Utah.

Name of Licensee (as it appears in our records): Meridian Meds LLC

Classification of License Issued: Pharmacy - Class B

License Number: 8455352-1704

Obtained By: Application

Current Status: Active

Original Date of Licensure: 11/21/2012

Expiration Date: 09/30/2021

Agency and Disciplinary Action: NO

Docket Number: N/A

The information provided on this form is accurate and correct as of the verification creation date listed on the top of this form. Original issue dates listed, as 01/01/1910 and 01/01/1911 were unknown when the division implemented its first licensing database. This verification form does not show a complete history or interruptions in licensure. If you have any questions please contact the division.

Copy of Current Registration

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

Certificate of License Renewal

Control Number: 8455352-1704-20190729

RENEWAL DATE: 07/29/2019

EXPIRATION DATE: 09/30/2021

ISSUED TO: Meridian Meds LLC

REFERENCE NUMBER(S), CLASSIFICATION(S) & DETAILS(S)

8455352-1704	Pharmacy - Class B
8455352-8913	Dispensing Controlled Substance License

Please note that DOPL reserves the right to initiate action at any time against a licensee who did not meet the renewal/reinstatement requirements at the time this license was issued.

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: Mixlab, Inc.

Physical Address: 336 W 37th St. Suite 850 New York, NY 10018

Mailing Address: 336 W 37th St. Suite 850 New York, NY 10018

City: New York State: NY Zip Code: 10018

Telephone: 888-901-4480 Fax: 212-967-0892

Toll Free Number: 888-901-4480 (Required per NAC 639.708)

E-mail: rita@mixlabrx.com Website: www.mixlabrx.com

Managing Pharmacist: Vinh Dam License Number: 059019

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: 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

Vinh Dam
Print Name of Authorized Person

2/4/20
Date

Board Use Only Date Processed: FEB 1 3 2020 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: _____

Mailing Address: Walker Rd, _____

City: Dover State: DE Zip: 19904

Telephone: 302-734-8300 Fax: _____

Contact Person: _____

For any corporation non publicly traded, disclose the following:

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

a) Frederic Dijols W 37th St. New York, NY 10018
Name Address

b) Stella Kim W 37th St New York, NY 10018
Name Address

c) Rocket Internet Capital Partners SCS Rue Lou Hemmer Luxembourg – Findel N4 L-1748
Name Address

d) Rocket Internet Capital Partners (Euro) Rue Lou Hemmer Luxembourg – Findel N4 L-1748
Name Address

2) Provide the number of shares issued by the corporation. 18,231,218

3) What was the price paid per share? 1.11652

4) What date did the corporation actually receive the cash assets? 4/30/2019

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 10 am 8 pm Saturday 10 am 8 pm

Sunday 10 am 2 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, Vinh Dam

Responsible Person of Mixlab, 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

Vinh Dam
Print Name of Authorized Person

2/4/20
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF New York)
) ss.
New York COUNTY)

I, Vinh Dam, 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 Mixlab, 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, VINH DAM, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

VINH DAM
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
4th day of February, 2020.

NOTARY PUBLIC

RITA KUPERSHTEYN
Notary Public, State of New York
Reg. No. 01KU6395259
Qualified in New York County
Commission Expires July 22, 2023

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "MIXLAB, 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 SEVENTEENTH DAY OF JANUARY, A.D. 2020.

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

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "MIXLAB, INC." WAS INCORPORATED ON THE TWENTY-EIGHTH DAY OF MARCH, A.D. 2017.

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

Jeffrey W. Bullock, Secretary of State

6362690 8300

SR# 20200290984

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

Authentication: 202209549

Date: 01-17-20

mixlab

Mixlab, Inc.
336 W 37th Street, Suite 850
New York, NY 10018

List of Mixlab Pharmacy Licenses

State	License Number	License Original Issue Date	License Expiration Date	License Status
New York	035768	9/19/17	8/31/20	Active
New Jersey	28RO00169300	3/16/18	6/30/20	Active
Connecticut	PCN.0003485	9/1/18	8/31/20	Active
Florida	PH 31978	3/29/19	2/28/21	Active
Maryland	P08079	4/18/19	5/31/20	Active
Ohio	242000092	4/24/19	3/31/21	Active
Pennsylvania	NP001335	4/8/19	8/31/20	Active
Virginia	214002207	7/3/19	7/31/20	Active
Washington D.C.	NRX1901612	7/30/19	5/31/21	Active
Tennessee	06785	9/25/19	9/30/21	Active
Rhode Island	PHN11748	9/30/2019	9/30/2020	Active
Georgia	PHNR001818	11/27/2019	6/30/2021	Active
Maine	MO40002742	12/4/2019	6/30/2021	Active
Minnesota	265948	10/11/2019	6/30/2020	Active
South Dakota	400-2052	12/20/19	6/30/2020	Active
Vermont	036.0134327	12/23/2019	7/31/2021	Active
California	NRP 2391	1/30/2020	6/15/2020	Active

Mixlab, Inc.
336 W 37th Street, Suite 850
New York, NY 10018

mixlab

Ownership Information

Mixlab Owners / Officers

Frederic Dijols, CEO

Stella Kim, CXO

Mixlab, Inc.
336 W 37th Street, Suite 850
New York, NY 10018

Mixlab Detailed Capitalization Table

As of 12/31/2019 • Generated by Frederic Dijols (fred@mixlabxr.com) at 01/16/2020 08:03:25

carta

Stakeholder ID	Name	Common (CS)	Series Seed-1 (SS1)	Series Seed-1 (SS1) 1:1 Conversion Ratio	Series Seed-2 (SS2)	Series Seed-2 (SS2) 1:1 Conversion Ratio	Series Seed-3 (SS3)	Series Seed-3 (SS3) 1:1 Conversion Ratio	Options and RSU's Outstanding Under 2017 Equity Incentive Plan	Common Warrants	Outstanding Shares	Fully Diluted Shares	Outstanding Ownership	Fully Diluted Ownership
dfec51e7f0ae05	2013 IGB US Trust						133,200	133,200			133,200	133,200	7.308%	0.6070%
be5780a1ffce2c	Alaric Capital, L.P.		335,866	335,866	256,002	256,002	130,309	130,309			722,177	722,177	3.9612%	3.2911%
b5b13c3e0e9cf	Animal Wellness Group LLC		8,957	8,957							8,957	8,957	0.491%	0.0408%
babb936ce572c	Arthur Chelly						67,252	67,252	25,000		67,252	92,252	3.688%	0.4204%
12c0ae09285c4	BFV Sidecar Fund II, LLC		22,391	22,391							22,391	22,391	1.228%	0.1020%
fc0336342225c	Brand Foundry Ventures Fund II, L.P.		425,430	425,430							425,430	425,430	2.3335%	1.9388%
284f3ac2a286c	Charles Gorra		8,957	8,957							8,957	8,957	0.491%	0.0408%
2631b12e06cdc	Companion Fund I, LLC				113,791	113,791				45,685	113,791	159,476	6.242%	0.7268%
fe228e00310dd	Dmitriy Likhten								50,000			50,000	0.000%	0.2279%
88498c723ebd7	Frederic Dijols	4,500,000							243,000		4,500,000	4,743,000	24.6829%	21.6149%
8dcd9fdffb576f	GFC Global Founders Capital GmbH		626,949	626,949							626,949	626,949	3.4389%	2.8572%
e8b1289874d2c	Global Founders Capital GmbH & Co. Beteiligun				76,282	76,282					76,282	76,282	4.184%	0.3476%
57800dd5138ef	GyanKapur, LLC						130,329	130,329			130,329	130,329	7.149%	0.5939%
1650bb158fc71	Hyperion LLC						66,600	66,600			66,600	66,600	3.653%	0.3035%
30dd8afe8d0a8	Jordan Bettman						66,600	66,600			66,600	66,600	3.653%	0.3035%
e9778aa8363bf	Joshua L. Guttman						67,794	67,794			67,794	67,794	3.719%	0.3090%
8ac6cdbb17f53	Joyance Partners, L.P.		67,174	67,174	192,302	192,302					259,476	259,476	1.4233%	1.1825%
8be49fc406193	Lakehouse Venture Partners Strategic Opportur		335,866	335,866							335,866	335,866	1.8423%	1.5309%
93d77257fb185	Lakehouse Venture Partners, LP				192,091	192,091	653,856	653,856			845,947	845,947	4.6401%	3.8552%
fc0f54e85dbf3	Lindsey DeJohn								5,000			5,000	0.000%	0.0228%
0002f72e3f220	Matt Minoff								25,000			25,000	0.000%	0.1139%
17902a5e19e3f	Matthieu Dederichs						26,804	26,804			26,804	26,804	1.470%	0.1222%
24754fdacbd9c	Maurice Dijols						403,997	403,997			403,997	403,997	2.2160%	1.8411%
3eb157df4a345	MFAF Impact Investment Fund, LLC				113,791	113,791				45,685	113,791	159,476	6.242%	0.7268%
231719cdb8fc1	Milestone Venture Partners LLC						65,365	65,365			65,365	65,365	3.585%	0.2979%
2dc40d9c7775	Monogram Capital Partners I, L.P.		895,641	895,641							895,641	895,641	4.9127%	4.0816%
fa8e14b85fe42	Narbona Hill Corporation						132,517	132,517			132,517	132,517	7.269%	0.6039%
258c62cc07c3f	Nikita DiGiacomo								5,000			5,000	0.000%	0.0228%
d9376ae821de4	Patric Pastore								5,000			5,000	0.000%	0.0228%
3fb521b3884c2	Patrick H. Cooper		35,826	35,826							35,826	35,826	1.965%	0.1633%
e44d7161ad90f	Paul Swaney						40,682	40,682			40,682	40,682	2.231%	0.1854%
38f28aca58fb4f	Project Mayhem Ventures, LLC						77,920	77,920			77,920	77,920	4.274%	0.3551%
303f5586021e7	R/GA Ventures VII, LLC				25,287	25,287					25,287	25,287	1.387%	0.1152%
8370bfc083a51	R/GA Ventures VII, LLC									45,685		45,685	0.000%	0.2082%
17cc05a7b973f	Resolute Venture Partners LP		134,347	134,347							134,347	134,347	7.369%	0.6123%
a0b6245d749c4	Rob Pfleging								51,559			51,559	0.000%	0.2350%
e32eb7a8b81fa	Rocket Internet Capital Partners (Euro) SCS		915,345	915,345	111,372	111,372					1,026,717	1,026,717	5.6316%	4.6780%
7e2a29c750ecf	Rocket Internet Capital Partners SCS		1,592,448	1,592,448	193,758	193,758					1,786,206	1,786,206	9.7975%	8.1402%
248b7e82dde6f	Samuel Bridges						40,682	40,682			40,682	40,682	2.231%	0.1854%
55403373af4b3	Sifen Investment Partners		22,392	22,392			202,661	202,661			225,053	225,053	1.2344%	1.0258%
8f0bb4f8187e9	Social Starts - A Pioneer, L.P.		33,766	33,766							33,766	33,766	1.852%	0.1539%
f98a7edeb9110	Social Starts - A, L.P.		55,798	55,798							55,798	55,798	3.061%	0.2543%
ef3063937ccd0	Stella Kim	4,000,000									4,000,000	4,000,000	21.9404%	18.2289%
0f869ed9e3c4b	TQ Ventures II LP		304,518	304,518							304,518	304,518	1.6703%	1.3878%
e681cd8e71cd3	Vinh Dam								1,031,000			1,031,000	.0000%	4.6965%
cd300aa6e969f	Weston Gaddy						66,600	66,600			66,600	66,600	3.653%	0.3035%
3751ee56b38c1	Xfactor 1, a series of Xfactor Ventures, LP						261,703	261,703			261,703	261,703	1.4356%	1.1926%
	Options and RSU's issued and outstanding								1,440,559					
	Shares available for issuance under the plan								2,134,315			2,134,315		9.7266%
	Fully diluted shares	**4,500,000**		**5,821,671**		**1,274,676**		**2,634,871**	**3,574,874**	**137,055**		**21,943,147**		**100.0000%**
	Fully **Diluted** Ownership	**20.5065%**		**26.5307%**		**5.8090%**		**12.0077%**	**16.2916%**	**.6246%**		**100.0000%**		
	Total Shares Outstanding	**4,500,000**	**5,821,671**		**1,274,676**		**2,634,871**				**18,231,218**		**100.0000%**	
	Percentage Outstanding	**24.6829%**	**31.9334%**		**6.9917%**		**14.4528%**				**100.0000%**			
	Price per share		**$ 1.11852**	**$ 1.11852**	**$ 0.81887**	**$ 0.81887**	**$ 0.40944**	**$ 0.40944**						

THE UNIVERSITY OF THE STATE OF NEW YORK
EDUCATION DEPARTMENT

NEW YORK STATE BOARD OF PHARMACY

SUPERVISING PHARMACIST
VINH DAM

2017-20

THIS IS TO CERTIFY

MIXLAB, INC.
336 WEST 37TH ST.
SUITE 850
NEW YORK, NY 10018

is duly recorded as a

REGISTERED PHARMACY

in conformity with the provisions of section 6808 of the Education Law

THIS CERTIFICATE IS EFFECTIVE ON THE NINETEENTH DAY OF SEPTEMBER, 2017.
THIS CERTIFICATE EXPIRES ON THE THIRTY-FIRST DAY OF AUGUST, 2020.

This certificate must be displayed conspicuously in the registered premises at all times. Authorization to operate a registered establishment is limited to the person and the premises indicated on the certificate. The regulations require the registrant to notify the Board of Pharmacy of any contemplated change in ownership, address or supervisor.

REGISTRATION NUMBER
035768

STATE BOARD OF
PHARMACY

NYSED.gov

Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

Pharmacy Establishment Information *

01/31/2020

Type : PHARMACY
Legal Name : MIXLAB, INC.
Trade Name :
Street Address :
336 WEST 37TH ST.
SUITE 850
NEW YORK, NY 10018-0000

Registration No : 035768
Date First Registered : 09/19/17
Registration Begins : 09/19/17
Registered through : 08/31/20
Supervisor : 059019 DAM VINH
Establishment Status : ACTIVE
Successor : NONE

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

- Use your browser's back key to return to establishment list.
- You may search to see if there has been recent disciplinary action against this registered establishment.

mixlab

Mixlab, Inc.
336 W 37th Street, Suite 850
New York, NY 10018

Dear Sir/Madam,

The State of New York does not do license verifications for pharmacy establishments. Attached is a copy of the online verification that is used in New York State as the official database and license verification.

Vinh Dam, Pharm.D.
Pharmacist in Charge

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*
☐ *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: NOB HILL DISCOUNT PHARMACY

Physical Address: 7650 N. NOB HILL [redacted]

Mailing Address: 7650 N. NOB HILL RD. [redacted]

City: TAMARAC State: FLORIDA Zip Code: 33321

Telephone: 954-537-6151 Fax: 954-532-9358

Toll Free Number: 888-511-1159 (Required per NAC 639.708)

E-mail: RPORTER@NOBHILLPHARMACY.COM Website: N/A

Managing Pharmacist: RICHARD PORTER License Number: PH30289

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

DANIEL RIESS
Print Name of Authorized Person

01/16/2020
Date

Board Use Only Date Processed: FEB 05 2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: FLORIDA

Parent Company if any: SRI VENKATESWARA

Mailing Address: 7650 N. NOB HILL RD

City: TAMARAC State: FLORIDA Zip: 33321

Telephone: 954-532-6151 Fax: 954-532-9358

Contact Person: DANIEL RIESS OR RICHARD PORTER

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 RIESS (Name) 1 VINLAND WAY, NAPLES, FL, 34105 (Address)

b) _____ (Name) _____ (Address)

c) _____ (Name) _____ (Address)

d) _____ (Name) _____ (Address)

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? 10/09/2019

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 4 pm Saturday 8 am 4 pm

Sunday CL am CL pm 24 Hours X

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, DANIEL RIESS

Responsible Person of NOB HILL DISCOUNT 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

DANIEL RIESS
Print Name of Authorized Person

01/16/2020
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF FLORIDA)
) ss.
BROWARD COUNTY)

I, DANIEL RIESS, 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 / OWNER for NOB HILL DISCOUNT 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, DANIEL RIESS, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

DANIEL RIESS
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
___day of_____, 20___.

_____
NOTARY PUBLIC

State of Florida
Department of State

I certify from the records of this office that SRI VENKATESWARA INC. is a corporation organized under the laws of the State of Florida, filed on January 16, 2015.

The document number of this corporation is P15000004754.

I further certify that said corporation has paid all fees due this office through December 31, 2019, that its most recent annual report/uniform business report was filed on April 2, 2019, and that its status is active.

I further certify that said corporation has not filed Articles of Dissolution.

Given under my hand and the Great Seal of the State of Florida at Tallahassee, the Capital, this the Thirteenth day of December, 2019

GREAT SEAL OF THE STATE OF FLORIDA
IN GOD WE TRUST

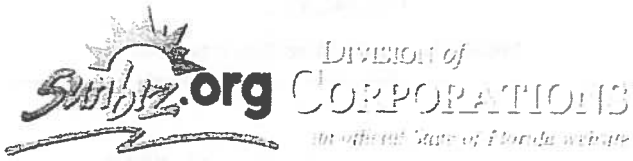
Secretary of State

Tracking Number: 6838332587CU

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

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

DIVISION OF CORPORATIONS



Detail by FEI/EIN Number

Florida Profit Corporation
SRI VENKATESWARA INC.

Filing Information

Document Number	P15000004754
FEI/EIN Number	47-2926598
Date Filed	01/16/2015
State	FL
Status	ACTIVE
Last Event	AMENDMENT
Event Date Filed	10/10/2019
Event Effective Date	NONE

Principal Address

7650 Nob Hill Road
Tamarac, FL 33321

Changed: 03/30/2016

Mailing Address

1 ASPEN LANE
WESTON, FL 33327

Registered Agent Name & Address

RIESS, DANIEL O
7650 Nob Hill Road
Tamarac, FL 33321

Name Changed: 10/10/2019

Address Changed: 10/10/2019

Officer/Director Detail

Name & Address

Title P,S,D

RIESS, DANIEL O
7650 NOB HILL ROAD
TAMARAC, FL 33321

Annual Reports

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

October 25, 2019

NOB Hill Pharmacy
7650 N Nob Hill Road
Tamarac, FL 33321

RE: License Certification for Sri Venkateswara Inc.

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:	PH30289
ORIGINAL CERTIFICATION:	08/05/2016
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

Officers/Directors: Nob Hill Discount Pharmacy

President/Owner:

Daniel Oliver Riess

2 Vinland Way

Naples, FL, 34105

AC#8751612

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/23/2019	PH 30289	108867

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

Expiration Date: FEBRUARY 28, 2021

SRI VENKATESWARA INC
NOB HILL DISCOUNT PHARMACY
7650 NOB HILL ROAD
TAMARAC, FL 33321

QUALIFICATION(S):
COMMUNITY PHARMACY
SCHEDULE II & III

Ron DeSantis
GOVERNOR

DISPLAY IF REQUIRED BY LAW

Sri Venkateswara Inc,

DBA Nob Hill Discount Pharmacy

7650 N Nob Hill Rd

Tamarac, FL 33321

954-532-6151

State Board of Pharmacy

To whom it may concern:

This letter is to notify you of a change in Pharmacist in Charge for Sri Venkateswara Inc, DBA Nob Hill Discount Pharmacy. Nob Hill Discount Pharmacy is located in Florida and retains an out of state or has applied for an out of state permit. The current Pharmacist in Charge, Richard Porter will be leaving effectively 1/30/2020. The new Pharmacist in Charge will be Allen MCSherry effective 1/31/2020. Please advise any additional documentation required for this change and provide acknowledgement to all parties that this letter has been received.

Richard Porter RPH, Pharmacist in Charge

JW 51st CT Coconut Creek, FL 33073

rporter@ipsinfusion.com

Daniel Riess President Owner

0 N Nob Hill Rd, Tamarac, FL 33321

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*** _____

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: SinfoniaRx, Inc.

Physical Address: 2001 W. Camelback Road, Suite 290

Mailing Address: 2001 W. Camelback Road, Suite 290

City: Phoenix State: AZ Zip Code: 85015

Telephone: 602-283-4339 Fax: 602-314-6027

Toll Free Number: 866-218-6646 (Required per NAC 639.708)

E-mail: Phoenix-Facility_Licenses@sinfoniarx.com Website: sinfoniarx.com

Managing Pharmacist: Kristin Calabro License Number: S017956

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: Non-dispensing	☐	☑ Sterile Compounding **
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding **
	For the application to be complete	☑	☐ Other Services: Medication Therapy Mgmt

****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.

KCalabro

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

Kristin Calabro

Print Name of Authorized Person

12/20/19

Date

Board Use Only Date Processed: 2-5-2020 Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Arizona

Parent Company if any: TRSHC Holdings, LLC

Mailing Address: 228 Strawbridge Dr., Suite 100

City: Moorestown State: NJ Zip: 08057

Telephone: 866-648-2767 Fax: 856-235-0797

Contact Person: Orsula V. Knowlton

For any corporation non publicly traded, disclose the following:

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

a) TRSHC Holdings, LLC - 228 Strawbridge Dr, Suite 100; Moorestown, NJ 08057
Name Address

b) _____
Name 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? 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: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8:00 am 5:30 pm Saturday 9:00 am 12:00 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

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Kristin Calabro

Responsible Person of SinfoniaRx, 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.

K Calabro

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

Kristin Calabro

Print Name of Authorized Person

12/20/19

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF ARIZONA)
) ss.
MARICOPA COUNTY)

I, Kristin Calabro, 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 Pharmacy Director for SinfoniaRx, 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, Kristin Calabro, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

K Calabro
Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
20th day of December, 2019.

Margaret Rochon
NOTARY PUBLIC

MARGARET ROCHON
Notary Public, State of Arizona
Pima County
Commission # 567033
My Commission Expires
July 07, 2023

ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520 Phoenix, AZ 85005
602-771-ASBP (2727)
FAX: 602-771-2749
http://www.azpharmacy.gov

Receipt Date: 10/04/2019
Receipt Number: 201971399
Receipt Amount $: 480.00

Pharmacy - Limited Service

PERMIT NO
Y008211

EXPIRES
10/31/2021

Issued to :

SinfoniaRx, Inc.
SinfoniaRx, Inc.
2001 W. CAMELBACK RD. SUITE 290
PHOENIX, AZ 85015

SinfoniaRx, Inc.
2001 W. CAMELBACK RD. SUITE 290
PHOENIX, AZ 85015

EXECUTIVE DIRECTOR

ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520
Phoenix, AZ 85005
602-771-ASBP (2727)
FAX: 602-771-2749

WALLET CARD

NAME : SinfoniaRx, Inc.
LICENSE NUMBER : Y008211
EXPIRES : 10/31/2021

http://www.azpharmacy.gov

- Your license must be available for inspections during business hours.
- Permit holder(s) must display permit in the location to which it is issued.
- Please note it is your responsibility to keep this license/permit current.

Important Information

LICENSE HOLDER (pharmacist, intern, technician, technician-trainee)

- Holder of this license number, printed above, is authorized in accordance with A.A.C. R4-23-201(A), A.A.C. R4-23-301(A) or A.A.C R4-23-1101(A), to perform the duties associated within their profession. By holding this license, the licensee agrees to comply with state & federal law.
- You are required by law to notify the Board of any home address and/or employment change within 10 business days

PERMIT HOLDER (pharmacy, non-prescription retailer (OTC), wholesale, manufacture, CMG, DME)

- Holder of this permit number, printed above, is authorized to conduct business according to the classification specified in A.R.S. § 32-1908(A); A.A.C. R4-23-601 and A.A.C. R4-23-607. By holding this permit, the permittee agrees to comply with state & federal law
- In-state pharmacy, wholesaler & manufacture permit holder(s) who plan to remodel or move locations, must submit a change-of-location/remodel form within 30 days prior to move/remodel. In-state non-prescription (OTC), compressed medical gas (CMG) & DME providers who plan to move locations must notify the board within 10 business days of move.
- Out-of-State permit holders must notify the Board of location changes, in writing, within 10 business days of move. A revised copy of your state permit shall be submitted to the Board, when available.
- Permits are non-transferable. Ownership changes of more than 30% require that a new application be submitted to the Board.

Arizona State Board of Pharmacy

Physical Address: 1616 W. Adams, Suite 120, Phoenix, AZ 85007
Mailing Address: P.O. Box 18520, Phoenix, AZ 85005
(P): 602-771-2727 (F): 602-771-2749 www.azpharmacy.gov

CERTIFICATION OF ARIZONA STATE BOARD OF PHARMACY PERMIT FOR THE ENTITY LISTED BELOW :

This document is not a license/permit but serves as the primary source of verification.

Name :	SinfoniaRx, Inc.
Address :	2001 W. Camelback Rd. Suite 290 Phoenix AZ 85015
License No :	Y008211
Permit Type :	Pharmacy
Sub Type :	Limited Service
Date Issued :	12/09/2019
Expiration Date :	10/31/2021
Status :	OPEN
Discipline :	No

Kam Gandhi

Kam Gandhi

Executive Director
Arizona State Board of Pharmacy

Date: 12/19/2019

19111214014652

STATE OF ARIZONA

Office of the
CORPORATION COMMISSION

CERTIFICATE OF GOOD STANDING

I, the undersigned Executive Director of the Arizona Corporation Commission, do hereby certify that:

SINFONIARX, INC.

ACC file number: 18695081

was incorporated under the laws of the State of Arizona on 08/26/2013;

That all annual reports owed to date by said corporation have been filed or delivered for filing, and all annual filing fees owed to date have been paid; and

That, according to the records of the Arizona Corporation Commission, said corporation is in good standing in the State of Arizona as of the date this Certificate is issued.

This Certificate relates only to the legal existence of the above named entity as of the date this Certificate is issued, and is not an endorsement, recommendation, or approval of the entity's condition, business activities, affairs, or practices.

IN WITNESS WHEREOF. I have hereunto set my hand, affixed the official seal of the Arizona Corporation Commission, and issued this Certificate on this date: **11/12/2019**

Matthew Neubert, Executive Director

Owner:

SinfoníaRx, Inc.
228 Strawbridge Dr., Suite 100
Moorestown, NJ 08057
(866) 648-2767
EIN: 90-1014939

Officers:

President
Orsula V. Knowlton, PharmD
Business Address: 228 Strawbridge Dr., Suite 100; Moorestown, NJ 08057
Residence Address: Pond View Drive; Moorestown, NJ 08057
Tel:
DOB:
SSN:

Chairperson
Calvin H. Knowlton, BScPharm, MDiv, PhD
Business Address: 228 Strawbridge Dr., Suite 100; Moorestown, NJ 08057
Residence Address: Pond View Drive; Moorestown, NJ 08057
Tel:
DOB:
SSN:

Secretary
Brian W. Adams
Business Address: 228 Strawbridge Dr., Suite 100; Moorestown, NJ 08057
Residence Address: Station Avenue; Haddonfield, NJ 08033
Tel:
DOB:
SSN:

SinfoníaRx
A Tabula Rasa HealthCare Company

100 North Stone Avenue · Suite 109
Tucson, Arizona · 85701

Description of Services

Patients with chronic illness face a number of challenges managing their day-to-day and long-term health, in part because medications are complex, confusing, costly and potentially dangerous. SinfoníaRx was founded to optimize medication use and improve the health of patients with chronic illness by providing Medication Therapy Management (MTM) services.

We offer a comprehensive approach to patient care and population health, with our team of dedicated pharmacists solely focused on providing medication reviews and clinical interventions to improve the health, wellness and the management of chronic health conditions.

SinfoníaRx, Inc. operates a pharmacist-run call center that provides phone-based medication therapy management (MTM) services. *This is not a retail or mail order pharmacy. It does not purchase, stock, compound, or dispense medications of any kind. Thus, it is not required to have either a state or federal controlled substance license.*

The Arizona State Board of Pharmacy has granted exemptions on items such as scales, balances, dispensing equipment, etc., as the pharmacy dispenses no medications. The Pharmacy Board also has exempted this pharmacy from counseling area requirements as the facility is not open to the general public and all sessions occur over the phone.

The pharmacists make outbound calls to patients Monday through Friday, from 8:00 AM to 5:30 PM and Saturday from 9:00 AM to 12:00 PM MST. After hours, incoming calls are routed to a service that provides patients access to a pharmacist 24 hours a day, 7 days a week.

The Pharmacy complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All patient records are only available to personnel as needed to provide service to patients. Paper records are kept in a secure storage system within the pharmacy.

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*
☐ *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: Somerset Pharmacy Inc

Physical Address: 101 S Main St. Somerset, KY 42501

Mailing Address: 101 S Main St

City: Somerset State: KY Zip Code: 42501

Telephone: 606-679-1571 Fax: 606-677-6845

Toll Free Number: 888-812-1107 (Required per NAC 639.708)

E-mail: somersetpharm1@gmail.com Website: N/A

Managing Pharmacist: Patricia Lee Steele License Number: 020966

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.

Patricia Lee Steele

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

Patricia Lee Steele
Print Name of Authorized Person

12-30-19
Date

Board Use Only Date Processed: 2-11-2020 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: N/A

Mailing Address: 101 S Main St

City: Somerset State: KY Zip: 42501

Telephone: 606-679-1571 Fax: 606-677-6845

Contact Person: Patricia Lee Steele

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. 0

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 9 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: N/A

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Patricia Lee Steele

Responsible Person of Somerset 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.

Patricia Lee Steele

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

Patricia Lee Steele
Print Name of Authorized Person

12-30-19
Date

Commonwealth of Kentucky
Alison Lundergan Grimes, Secretary of State

Alison Lundergan Grimes
Secretary of State
P. O. Box 718
Frankfort, KY 40602-0718
(502) 564-3490
http://www.sos.ky.gov

Certificate of Existence

Authentication number: 221799
Visit https://app.sos.ky.gov/ftshow/certvalidate.aspx to authenticate this certificate.

I, Alison Lundergan Grimes, Secretary of State of the Commonwealth of Kentucky, do hereby certify that according to the records in the Office of the Secretary of State,

SOMERSET PHARMACY, INC. OF KY

is a corporation duly incorporated and existing under KRS Chapter 14A and KRS Chapter 271B, whose date of incorporation is July 23, 2003 and whose period of duration is perpetual.

I further certify that all fees and penalties owed to the Secretary of State have been paid; that Articles of Dissolution have not been filed; and that the most recent annual report required by KRS 14A.6-010 has been delivered to the Secretary of State.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Official Seal at Frankfort, Kentucky, this 23rd day of October, 2019, in the 228th year of the Commonwealth.

COMMONWEALTH OF KENTUCKY
OFFICE OF SECRETARY OF STATE

Alison Lundergan Grimes
Alison Lundergan Grimes
Secretary of State
Commonwealth of Kentucky
221799/0564520

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: 06/01/2000

NUMBER: P06577

EXPIRATION DATE: 06/30/2020

PIC: PATRICIA LEE STEELE

Issued to:
SOMERSET PHARMACY

101 S MAIN ST
SOMERSET, KY 42501

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.

somersetrx@yahoo.com

100% OWNER: SOMERSET PHARMACY LLC

LAWRENCE WEISS, MANAGING MEMBER

S MAIN STREET

SOMERSET, KY 42501

PHONE:

BUSINESS PHONE: 606-679-1571

DOB:

4P

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: **Truepill NY LLC**

Physical Address: **850 3rd Ave STE 404 Brooklyn, NY 11232**

Mailing Address: **Same as Physical Address**

City: _____ State: _____ Zip Code: _____

Telephone: **(518) 692 - 3362** Fax: **(718) 499 - 3362**

Toll Free Number: **(855) 687 - 8369** (Required per NAC 639.708)

E-mail: **joshua@truepill.com** Website: **N/A**

Managing Pharmacist: **Joshua Reiter** License Number: **061076**

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

Joshua Reiter
Print Name of Authorized Person

1/29/20
Date

Board Use Only Date Processed: 2-11-2020 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: **Postmeds Inc.**

Mailing Address: **1700 S. Amphlett Blvd STE 221**

City: **San Mateo** State: **CA** Zip: **94402**

Telephone: **(650) 353 - 5495** Fax: **(650) 435-5932**

Contact Person: **Joshua Reiter**

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 - Truepill NY LLC is legally 100% owned by Postmeds Inc. There are 0 shares.**
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. **0**

3) What was the price paid per share? **0**

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** %: **0**

Name: **N/A** %: **0**

Hours of Operation for the pharmacy:

Monday thru Friday **9** am **6** pm Saturday **N/A** am **N/A** pm

Sunday **N/A** am **N/A**pm 24 Hours **Toll-Free Number - Pharmacist Consultation**

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

Founder/CEO: Mohammad (Umar) Afridi
Pharmacist-in-Charge: Joshua Reiter

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, **Joshua Reiter**

Responsible Person of **Truepill NY 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

Joshua Reiter
Print Name of Authorized Person

1/29/20
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF New York)
) ss.
Kings COUNTY)

I, Joshua Reiter, 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 Truepill NY 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, Joshua Reiter, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

Name

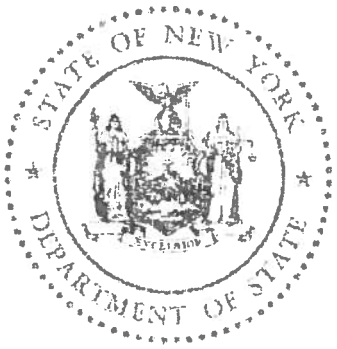
SUBSCRIBED AND SWORN TO
before me, a notary public this
5th day of FEBRUARY, 2020.

NOTARY PUBLIC

Tamara Bourdeau
Notary Public, State of New York
No. 01BO6099396
Qualified in Kings County
Commission Expires Sept 29, 2023

State of New York
Department of State } ss:

I hereby certify, that TRUEPILL NY LLC a NEW YORK Limited Liability Company filed Articles of Organization pursuant to the Limited Liability Company Law on 02/25/2019, and that the Limited Liability Company is existing so far as shown by the records of the Department.



***

WITNESS my hand and the official seal of the Department of State at the City of Albany, this 14th day of November two thousand and nineteen.

Brendan C. Hughes

Brendan C Hughes
Executive Deputy Secretary of State

201911150279 02

NYSED.gov

Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

Pharmacy Establishment Information *

08/15/2019

Type : PHARMACY
Legal Name : TRUEPILL NY LLC
Trade Name :
Street Address :
850 THIRD AVE.
STE 404
BROOKLYN, NY 11232-0000

Registration No : 037429
Date First Registered : 08/02/19
Registration Begins : 08/02/19
Registered through : 07/31/22
Supervisor : 061076 REITER JOSHUA
Establishment Status : ACTIVE
Successor : NONE

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

- Use your browser's back key to return to establishment list.
- You may search to see if there has been recent disciplinary action against this registered establishment.

THE UNIVERSITY OF THE STATE OF NEW YORK
EDUCATION DEPARTMENT

NEW YORK STATE BOARD OF PHARMACY

SUPERVISING PHARMACIST
JOSHUA REITER

2019-22

THIS IS TO CERTIFY

TRUEPILL NY LLC
850 THIRD AVE.
STE 404
BROOKLYN, NY 11232

is duly recorded as a

REGISTERED PHARMACY

in conformity with the provisions of section 6808 of the Education Law

THIS CERTIFICATE IS EFFECTIVE ON THE SECOND DAY OF AUGUST, 2019.
THIS CERTIFICATE EXPIRES ON THE THIRTY-FIRST DAY OF JULY, 2022.

This certificate must be displayed conspicuously in the registered premises at all times. Authorization to operate a registered establishment is limited to the person and the premises indicated on the certificate. The regulations require the registrant to notify the Board of Pharmacy of any contemplated change in ownership, address or supervisor.

REGISTRATION NUMBER
037429

Kimberly A. Leonard
EXECUTIVE SECRETARY
STATE BOARD OF PHARMACY

4Q

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: NATIONAL PHARMACY

Physical Address: 7420 SANTA MONICA BLVD, WEST HOLLYWOOD, CA 90046

Mailing Address: SAME

City: WEST HOLLYWOOD State: CA Zip Code: 90046

Telephone: 323-851-4444 Fax: 323-851-4445

Toll Free Number: 800-994-8990 (Required per NAC 639.708)

E-mail: pharmacynational@yahoo.com Website: _____

Managing Pharmacist: Audrey Toledano License Number: 68911

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.

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

Audrey Toledano
Print Name of Authorized Person

12/20/19
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: Santa Monica BLVD

City: West Hollywood State: Ca Zip: 90046

Telephone: 323-851-4444 Fax: 323-851-4445

Contact Person: Michael Imanoel

For any corporation non publicly traded, disclose the following:

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

a) Michael Imanoel (Name) S. Holt Ave, Los Angeles, Ca 90035 (Address)

b) _____ (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? No part value

4) What date did the corporation actually receive the cash assets? NOV/17/2009

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: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 4 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: _____

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF California)
) ss.
Los Angeles COUNTY)

I, Michael Mehrdad Imanpour, 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 National 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, Michael Mehrdad Imanpour 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
17 day of Dec, 2019.

Chul Woo Lee
NOTARY PUBLIC

CHUL WOO LEE
NOTARY PUBLIC - CALIFORNIA
LOS ANGELES COUNTY
COMMISSION # 2271313
MY COMM. EXPIRES DEC. 16, 2022

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Audrey Toledano

Responsible Person of National 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.

Toledano

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

Audrey Toledano

Print Name of Authorized Person

12/20/19

Date

California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

December 13, 2019

NATIONAL PHARMACY
7420 SANTA MONICA BLVD
WEST HOLLYWOOD CA 90046

California State Board of Pharmacy License Verification

This document reflects the license status of the person or entity identified below on this date with the California State Board of Pharmacy. It may be used as prima facie evidence of the facts recited below pursuant to California Business and Professions Code section 162.

Licensee Name: NATIONAL PHARMACY

License Type: PHARMACY

License Number: PHY 50363

Status: ACTIVE

Issue Date: 07/22/10

Expiration Date: 07/01/20

Address of Record: 7420 SANTA MONICA BLVD WEST HOLLYWOOD CA 90046

Disciplinary Action: NO RECORD OF DISCIPLINARY ACTION

Anne Sodergren
Interim Executive Officer

By

Barbera Schleicher
Public Inquiry Analyst
(916) 518-3081
Barbera.Schleicher@dca.ca.gov

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: National Pharmacy

Address: 7420 Santa Monica Blvd

City: West Hollywood State: CA Zip: 90046,

I hereby authorize the CA state board of pharmacy to furnish to the Nevada State Board of Pharmacy, the information requested below.

Signature of Applicant [signature]

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

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

Renewal Certificate

Retail Pharmacy Permit

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

LICENSE NO. PHY 50363
RECEIPT NO. 91280683

VALID UNTIL JULY 01, 2020

NATIONAL PHARMACY
7420 SANTA MONICA BLVD
WEST HOLLYWOOD CA 90046-5605

In accordance with the Provisions of Chapter 9 of Division 2 of the Business and Professions Code, the firm name hereon is licensed at the address shown, 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 within 30 days when there is a change of ownership, location, corporate officer, director, shareholder (more than 10 percent share change) administrator or pharmacist-in-charge.
This permit is valid only at the address shown.

10/19

10/19 The official status of this license can be verified at www.pharmacy.ca.gov

----- NON-TRANSFERABLE --- POST IN PUBLIC VIEW -----

FORM WPHPHY (12/31/05) PH

State of California
Secretary of State
CERTIFICATE OF STATUS

ENTITY NAME:

NATIONAL PHARMACY, INC.

FILE NUMBER:	C3260502
FORMATION DATE:	11/17/2009
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 December 31, 2019.

ALEX PADILLA
Secretary of State

CFG

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: ALLY MEDICAL SERVICES dba ACENTUS

Physical Address: 4951-B E ADAMO DRIVE, SUITE 220 TAMPA, FL 33605-5913

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

Mailing Address: 4951-B E ADAMO DRIVE, SUITE 220

City: TAMPA State: FL Zip Code: 33605-5913

Telephone: 866-684-2507 Fax: 866-695-2183

E-mail: TODDC@ACENTUS365.COM Website: ACENTUS365.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: N/A to Sun: N/A to Holidays: N/A to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: TODD CIANFROCCA

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

☐ Medical Gases** ☐ Assistive Equipment

☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**

☐ Life-sustaining equipment** ☐ Orthotics and Prosethics

☒ Diabetic Supplies 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: 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:

661662000I - MEDICARE
661662000 2 - MEDICARE
00443810O - FL
1396140737 - NC
DE3878 - SC
1881972040 - IA
7100290040 - KY
01105203 6 - WASHINGTON DC
1881972040 - WASHINGTON STATE

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 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.

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

TODD CIANFROCCA
Print Name of Authorized Person

01/16/2020
Date

Board Use Only	Received: FEB 0 5 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION N/A

State of Incorporation: _____

Parent Company if any: _____

Corporation Name: _____

Mailing Address: _____

City:_____ State:_____ Zip: _____

Telephone:_____ Fax:_____

License Contact Person: _____

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._____ %: _____

2._____ %: _____

3._____ %: _____

4._____ %: _____

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: _____

Registration number issued: _____

Stock Exchange: _____

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

OWNERSHIP IS A PARTNERSHIP General ____ Limited ✓

Partnership Name: ACENTUS LLC

Mailing Address: 4951-B E ADAMO DRIVE, SUITE 220

City: TAMPA State: FL Zip: 33605-5913

Telephone: 866-684-2507 Fax: 866-695-2183

Contact Person: TODD CIANFROCCA

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
TODD CIANFROCCA	L	28%
JULIO VALDIVIA	L	28%

List names of 4 largest partners and percentage of ownership:

Name: GREGORY DUVALL (L) %: 22%

Name: BRETT CARROLL (L) %: 22%

Name: TODD CIANFROCCA (L) %: 28%

Name: JULIO VALDIVIA (L) %: 28%

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION N/A

State of Incorporation: _____

Parent Company if any: _____

Corporation Name: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Telephone:_____ Fax:_____

Contact Person: _____

For any corporation non-publicly traded, disclose the following:

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

a)_____
Name Address

b)_____
Name Address

c)_____
Name Address

d)_____
Name Address

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

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

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.

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/1/2019

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
VGM Insurance Services, Inc.
1111 W. San Marnan Dr.
Waterloo IA 50701

CONTACT NAME: Ashley Haynes
PHONE (A/C, No, Ext): (844) 346-3937 FAX (A/C, No):
E-MAIL ADDRESS: Ashley.Haynes@vgm.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : STATE NATIONAL INSURANCE CO	12831
INSURER B : STATE NATIONAL INSURANCE CO	12831
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Ally Medical Services LLC; Acentus, LLC
4951-B Adamo Drive East #220
Tampa FL 33605

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			VGM D1019 G5261-5	10/29/2019	10/29/2020	EACH OCCURRENCE	$	1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	100,000
	X Professional Liability						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							$	
B	AUTOMOBILE LIABILITY			VGM D1019 G5261-5	10/29/2019	10/29/2020	COMBINED SINGLE LIMIT (Ea accident)	$	1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$	
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$	
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$	
								$	
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$	
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$	
	DED RETENTION $							$	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE / OTH-ER		
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N N/A (Mandatory in NH)						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)

FEIN: 45-2398815

Locations:
4951-B Adamo Drive East #220 Tampa FL 33605
127 North Broad Street Ste A Brevard NC 28712

CERTIFICATE HOLDER

National Supplier Clearinghouse~AG-495
PO Box 100142
Columbia SC 29202314

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

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

(**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 MP01497)

☐ 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: AdaptHealth Patient Care Solutions Inc.

Physical Address: 1667 Shug Jordan Parkway, Suite 403, Auburn, AL 36830

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

Mailing Address: 220 W. Germantown Pike, Suite 250

City: Plymouth Meeting State: PA Zip Code: 19462

Telephone: 855-404-6727 Fax: 855-237-0017

E-mail: licensing@adapthealth.com Website: adapthealth.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: Person in charge on a daily basis

Name: Savannah Lamb

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 Blood glusose, Incontinence
Other: Woundcare, Ostomy, Tracheostomy, Urological

**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: Savannah Lamb Telephone: 334-539-6549

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 #0208980005		
Medicaid #123509		

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: N/A
- 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.

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

Joe Paiva
Print Name of Authorized Person

2/11/2020
Date

Board Use Only	Received: FEB 13 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP General X Limited _____

Partnership Name: AdaptHealth Patient Care Solutions Inc.

Mailing Address: W. Germantown Pike, Suite 2

City: Plymouth Meeting State: PA Zip: 19462

Telephone: 610-630-6357 Fax: _____

Contact Person: Shirley Skidmore

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
NRE Holding Corporation	G	100%

List names of 4 largest partners and percentage of ownership:

Name: NRE Holding Corporation %: 100%

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 2/6/2020 | 1/13/2019

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 Lockton Companies 1185 Avenue of the Americas, Suite 2010 New York NY 10036 646-572-7300	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Philadelphia Indemnity Insurance Co.	18058
INSURER B : Hartford Fire Insurance Company	19682
INSURER C : Hartford Underwriters Insurance Company	30104
INSURER D : Twin City Fire Insurance Company	29459
INSURER E : Coverys	14160
INSURER F :	

INSURED 1423544 AdaptHealth, LLC
122 Mill Road
Suite A130
Phoenixville PA 19460

COVERAGES **CERTIFICATE NUMBER:** 15605799 **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 CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	N	N	PHPK1982856	5/17/2019	5/17/2020	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 $ $100,000 $ $5,000 $ $1,000,000 $ $3,000,000 $ $3,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	N	N	39CSES65401	2/6/2019	2/6/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $	N	N	PHUB676308	5/17/2019	5/17/2020	EACH OCCURRENCE AGGREGATE	$ $5,000,000 $ $5,000,000
C D	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	N	39WNS65400 39WBRS65402 (WI)	2/6/2019 2/6/2019	2/6/2020 2/6/2020	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $1,000,000 $ $1,000,000 $ $1,000,000
A E	Prof Liab. Property	N	N	PHPK1982856 005PA000026190	5/17/2019 5/17/2019	5/17/2020 5/17/2020	$1M each medical incident/$3M Agg Limit: $51,930,048	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
THIS CERTIFICATE SUPERSEDES ALL PREVIOUSLY ISSUED CERTIFICATES FOR THIS HOLDER, APPLICABLE TO THE CARRIERS LISTED AND THE POLICY TERM(S) REFERENCED

CERTIFICATE HOLDER

15605799
Evidence of Insurance

CANCELLATION See Attachment

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 Michael P. Calabrese

NAMED INSUREDS

AdaptHealth LLC
AdaptHealth Holdings LLC
Roberts Home Medical, LLC
Home Mediservice, LLC
TriCounty Medical Equipment and Supply, LLC
Royal Medical Supply Inc.
Royal Homestar LLC
First Choice Home Medical Equipment, LLC
Americoast Maryland LLC
Ocean Home Health Supply LLC
Med-Equip, Inc.
Health Solutions LLC
Ocean Home Health of PA LLC
Inspire Medical Equipment & Services, Inc.
LMI DME Holdings LLC
Medstar Holdings LLC
Med Star Surgical & Breathing Equipment Inc.
Family Home Medical Supply LLC
First Choice DME LLC
Royal DME LLC
Braden Partners, L.P.
Bennett Medical Services LLC
CPAP Solutions, LLC
MedBridge Home Medical LLC
Ogles Oxygen, LLC
Palmetto Oxygen, LLC
PPS HME Holdings LLC
SleepEasy Therapeutics, Inc.
Sound Oxygen Service LLC
Southeast Sleep Holdings, LLC
Verus Healthcare, Inc.
Verus Healthcare, LLC
Cpap2me, Inc.
Aircare Home Respiratory, LLC
Hometown Home Health, LLC
Total Respiratory, LLC
PPS HME LLC
Clearview Medical Incorporated
Associated Healthcare Systems, Inc.
Olean General Healthcare Systems, LLC
Orbit Medical of Portland, Inc.
Home Medical Express, Inc.
Gould's Discount Medical, LLC
(a Kentucky limited liability company)
Med Way Medical, Inc. (a Utah corporation)
AdaptHealth Intermediate Holdco LLC
AdaptHealth - Missouri LLC (a Missouri limited liability
American Ancillaries, Inc. dba AA Medical
Choice Medical Healthcare LLC
Halprin, Inc.
AdaptHealth Patient Care Solutions

4T

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 MP01082)

☐ 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: AdaptHealth Patient Care Solutions Inc.

Physical Address: 600 Lindbergh Drive, Moon Township, PA 15108

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

Mailing Address: 220 W. Germantown Pike, Suite 250

City: Plymouth Meeting State: PA Zip Code: 19462

Telephone: 855-404-6727 Fax: 855-237-0017

E-mail: licensing@adapthealth.com Website: adapthealth.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:30am to 5pm Tue: 8:30am to 5pm Wed: 8:30am to 5pm Thu: 8:30am to 5pm Fri: 8:30am to 5pm

Sat: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Rodney Carson

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 Blood glusose, Incontinence
Other: Woundcare, Ostomy, Tracheostomy, Urological

**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: Rodney Carson Telephone: 412-474-1743

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 #0208980001	_____	_____
Medicaid#15014850007	_____	_____
_____	_____	_____

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: N/A
- 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.

Joseph J. Paiva

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

Joe Paiva

Print Name of Authorized Person

2/11/2020

Date

Board Use Only	Received: FEB 13 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP General X Limited _____

Partnership Name: AdaptHealth Patient Care Solutions Inc.

Mailing Address: 220 W. Germantown Pike, Suite 250

City: Plymouth Meeting State: PA Zip: 19462

Telephone _____ Fax: _____

Contact Person: Shirley Skidmore

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
NRE Holding Corporation	G	100%

List names of 4 largest partners and percentage of ownership:

Name: NRE Holding Corporation %: 100%

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

2/6/2020

DATE (MM/DD/YYYY) 1/13/2019

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PRODUCER Lockton Companies 1185 Avenue of the Americas, Suite 2010 New York NY 10036 646-572-7300	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:

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INSURER A : Philadelphia Indemnity Insurance Co.	18058
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INSURER C : Hartford Underwriters Insurance Company	30104
INSURER D : Twin City Fire Insurance Company	29459
INSURER E : Coverys	14160
INSURER F :	

INSURED 1423544
AdaptHealth, LLC
122 Mill Road
Suite A130
Phoenixville PA 19460

COVERAGES **CERTIFICATE NUMBER:** 15605799 **REVISION NUMBER:** XXXXXXX

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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:	N	N	PHPK1982856	5/17/2019	5/17/2020	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 $ $100,000 $ $5,000 $ $1,000,000 $ $3,000,000 $ $3,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	N	N	39CSES65401	2/6/2019	2/6/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX
A	X UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [ ] RETENTION $	N	N	PHUB676308	5/17/2019	5/17/2020	EACH OCCURRENCE AGGREGATE	$ $5,000,000 $ $5,000,000
C D	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	N	39WNS65400 39WBRS65402 (WI)	2/6/2019 2/6/2019	2/6/2020 2/6/2020	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $1,000,000 $ $1,000,000 $ $1,000,000
A E	Prof Liab. Property	N	N	PHPK1982856 005PA000026190	5/17/2019 5/17/2019	5/17/2020 5/17/2020	$1M each medical incident/$3M Agg Limit: $51,930,048	

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CERTIFICATE HOLDER

15605799
Evidence of Insurance

CANCELLATION See Attachment

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 Michael P Calabrese

NAMED INSUREDS

AdaptHealth LLC
AdaptHealth Holdings LLC
Roberts Home Medical, LLC
Home Mediservice, LLC
TriCounty Medical Equipment and Supply, LLC
Royal Medical Supply Inc.
Royal Homestar LLC
First Choice Home Medical Equipment, LLC
Americoast Maryland LLC
Ocean Home Health Supply LLC
Med-Equip, Inc.
Health Solutions LLC
Ocean Home Health of PA LLC
Inspire Medical Equipment & Services, Inc.
LMI DME Holdings LLC
Medstar Holdings LLC
Med Star Surgical & Breathing Equipment Inc.
Family Home Medical Supply LLC
First Choice DME LLC
Royal DME LLC
Braden Partners, L.P.
Bennett Medical Services LLC
CPAP Solutions, LLC
MedBridge Home Medical LLC
Ogles Oxygen, LLC
Palmetto Oxygen, LLC
PPS HME Holdings LLC
SleepEasy Therapeutics, Inc.
Sound Oxygen Service LLC
Southeast Sleep Holdings, LLC
Verus Healthcare, Inc.
Verus Healthcare, LLC
Cpap2me, Inc.
Aircare Home Respiratory, LLC
Hometown Home Health, LLC
Total Respiratory, LLC
PPS HME LLC
Clearview Medical Incorporated
Associated Healthcare Systems, Inc.
Olean General Healthcare Systems, LLC
Orbit Medical of Portland, Inc.
Home Medical Express, Inc.
Gould's Discount Medical, LLC
(a Kentucky limited liability company)
Med Way Medical, Inc. (a Utah corporation)
AdaptHealth Intermediate Holdco LLC
AdaptHealth - Missouri LLC (a Missouri limited liability
American Ancillaries, Inc. dba AA Medical
Choice Medical Healthcare LLC
Halprin, Inc.
AdaptHealth Patient Care Solutions

4U

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 MP01534)

☐ 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: AdaptHealth Patient Care Solutions Inc.

Physical Address: 2 Twosome Drive, Moorestown, NJ 08057

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

Mailing Address: 220 W. Germantown Pike, Suite 250

City: Plymouth Meeting State: PA Zip Code: 19462

Telephone: 855-404-6727 Fax: 855-237-0017

E-mail: licensing@adapthealth.com Website: adapthealth.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:30am to 5pm Tue: 8:30am to 5pm Wed: 8:30am to 5pm Thu: 8:30am to 5pm Fri: 8:30am to 5pm Sat: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Tyrone Taylor Jr.

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 Blood glusose, Incontinence
Other: Woundcare, Ostomy, Tracheostomy, Urological

**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: Tyrone R. Taylor Jr. Telephone: 856-437-1912

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 #0208980015		
Medicaid #113326		

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

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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.

Joseph J. Paiva
Original Signature of Person Authorized to Submit Application, no copies or stamps

Joe Paiva
Print Name of Authorized Person

2/11/2020
Date

Board Use Only	Received: FEB 13 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP General X Limited _____

Partnership Name: AdaptHealth Patient Care Solutions Inc.

Mailing Address: 220 W. Germantown Pike, Suite 250

City: Plymouth Meeting State: PA Zip: 19462

Telephon _____ Fax: _____

Contact Person: Shirley Skidmore

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

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List names of 4 largest partners and percentage of ownership:

Name: NRE Holding Corporation %: 100%

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 2/6/2020 | 1/13/2019

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PRODUCER Lockton Companies 1185 Avenue of the Americas, Suite 2010 New York NY 10036 646-572-7300	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED 1423544 AdaptHealth, LLC 122 Mill Road Suite A130 Phoenixville PA 19460	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Philadelphia Indemnity Insurance Co. 18058 INSURER B : Hartford Fire Insurance Company 19682 INSURER C : Hartford Underwriters Insurance Company 30104 INSURER D : Twin City Fire Insurance Company 29459 INSURER E : Coverys 14160 INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 15605799 **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 CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	N	N	PHPK1982856	5/17/2019	5/17/2020	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 $ $100,000 $ $5,000 $ $1,000,000 $ $3,000,000 $ $3,000,000 $
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	N	N	39CSES65401	2/6/2019	2/6/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ $1,000,000 $ XXXXXXX $ XXXXXXX $ XXXXXXX $ XXXXXXX
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $	N	N	PHUB676308	5/17/2019	5/17/2020	EACH OCCURRENCE AGGREGATE 	$ $5,000,000 $ $5,000,000 $ XXXXXXX
C D	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	N	39WNS65400 39WBRS65402 (WI)	2/6/2019 2/6/2019	2/6/2020 2/6/2020	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $1,000,000 $ $1,000,000 $ $1,000,000
A E	Prof Liab. Property	N	N	PHPK1982856 005PA000026190	5/17/2019 5/17/2019	5/17/2020 5/17/2020	$1M each medical incident/$3M Agg Limit: $51,930,048	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
THIS CERTIFICATE SUPERSEDES ALL PREVIOUSLY ISSUED CERTIFICATES FOR THIS HOLDER, APPLICABLE TO THE CARRIERS LISTED AND THE POLICY TERM(S) REFERENCED

CERTIFICATE HOLDER

15605799
Evidence of Insurance

CANCELLATION See Attachment

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 Michael P Calabrese

Attachment Code: D568304 Certificate ID: 15605799

NAMED INSUREDS

AdaptHealth LLC
AdaptHealth Holdings LLC
Roberts Home Medical, LLC
Home Mediservice, LLC
TriCounty Medical Equipment and Supply, LLC
Royal Medical Supply Inc.
Royal Homestar LLC
First Choice Home Medical Equipment, LLC
Americoast Maryland LLC
Ocean Home Health Supply LLC
Med-Equip, Inc.
Health Solutions LLC
Ocean Home Health of PA LLC
Inspire Medical Equipment & Services, Inc.
LMI DME Holdings LLC
Medstar Holdings LLC
Med Star Surgical & Breathing Equipment Inc.
Family Home Medical Supply LLC
First Choice DME LLC
Royal DME LLC
Braden Partners, L.P.
Bennett Medical Services LLC
CPAP Solutions, LLC
MedBridge Home Medical LLC
Ogles Oxygen, LLC
Palmetto Oxygen, LLC
PPS HME Holdings LLC
SleepEasy Therapeutics, Inc.
Sound Oxygen Service LLC
Southeast Sleep Holdings, LLC
Verus Healthcare, Inc.
Verus Healthcare, LLC
Cpap2me, Inc.
Aircare Home Respiratory, LLC
Hometown Home Health, LLC
Total Respiratory, LLC
PPS HME LLC
Clearview Medical Incorporated
Associated Healthcare Systems, Inc.
Olean General Healthcare Systems, LLC
Orbit Medical of Portland, Inc.
Home Medical Express, Inc.
Gould's Discount Medical, LLC
(a Kentucky limited liability company)
Med Way Medical, Inc. (a Utah corporation)
AdaptHealth Intermediate Holdco LLC
AdaptHealth - Missouri LLC (a Missouri limited liability
American Ancillaries, Inc. dba AA Medical
Choice Medical Healthcare LLC
Halprin, Inc.
AdaptHealth Patient Care Solutions

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: WP&H,LLC dba Military Medical Supplies

Physical Address: 1440 S State College Blvd #5H Anaheim CA 92806
(This must be a business address, we cannot issue a license to a home address)

Mailing Address: 1440 S State College Blvd #5H Anaheim CA 92806

City:_____ State:_____ Zip Code: _____

Telephone: 800-270-6990 Fax: 800-497-8856

E-mail: dcscheidt@militarymedical.us.com Website: www.militarymedical.us.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: David Scheidt; Owner

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: Tricare Telephone: 800-444-5445

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:

4503770001 Medicare		

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.

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

David Scheidt; Owner
Print Name of Authorized Person

12/11/2019
Date

Board Use Only	Received: FEB 0 5 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: California

Parent Company if any: N/A

Corporation Name: WP&H,LLC

Mailing Address: 1440 S State College Blvd #5H Anaheim CA 92806

City:_____ State:_____ Zip:_____

Telephone: 800-270-6990 Fax: 800-497-8856

Contact Person: David Scheidt

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

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.

MMS MILITARY MEDICAL SUPPLIES
Serving Those Who Serve America

December 11, 2019

List of Owners

Owner Name	% Ownership	Address
David Scheidt	49%	Dietrich Dr. Tustin CA 92782
Levy Bynum	51%	Tamarack Way Buena Park CA 90620

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME: WP&H, LLC

FILE NUMBER:	200208610093
FORMATION DATE:	03/25/2002
TYPE:	DOMESTIC LIMITED LIABILITY COMPANY
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 April 22, 2016.

ALEX PADILLA
Secretary of State

MMS

NP-25 (REV 01/2015)

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/9/2019

PRODUCER
The Millward Agency, Inc.
11142 N Highland Blvd #300
Highland , UT 84003

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Philadelphia	
INSURER B: Markel	
INSURER C:	
INSURER D:	
INSURER E:	

INSURED
WP&H,LLC dba California Medical Supplies, Military Medical Supplies, American Medical Supplies, Cal-Med Hawaii
1440 S State College Blvd #5H
Anaheim, CA 92806

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY ✓ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ✓ OCCUR ✓ Professional Liability GEN'L AGGREGATE LIMIT APPLIES PER: ✓ POLICY ☐ PRO-JECT ☐ LOC	PHPK1966200	04/18/2019	04/18/2020	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1000000 $ 1000000 $ 20000 $ 1000000 $ 3000000 $ 3000000
A		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)	$ $ $ $
		GARAGE LIABILITY ☐ ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
		EXCESS/UMBRELLA LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE ☐ RETENTION $				EACH OCCURRENCE AGGREGATE	$ $
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	MWC012629302	04/18/2019	04/18/2020	✓ WC STATU-TORY LIMITS ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1000000 $ 1000000 $ 1000000
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
99-061 Koaha Way, Suite 203-204 Aiea, HI 96701
This Certificate verifies that coverage is currently in force.

*Except for 10-Day Notice of Cancellation for Non-Payment of Premium.

CERTIFICATE HOLDER
National Supplier Clearinghouse

PO Box 100142
Columbia, SC 29202-3142

CANCELLATION
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 NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

WP&H, LLC

Anaheim, CA

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

July 21, 2017

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #365548
Print/Reprint Date: 10/27/2017

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care a other services provided in accredited organizations. Information about accredited organizations may be provided directly The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.




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BUSINESS TAX CERTIFICATE

POST CERTIFICATE IN A CONSPICUOUS PLACE

This certificate is not transferable or assignable. This certificate evidences that the person(s), firm or entity named herein paid the applicable tax required by Title 3 of the Anaheim Municipal Code for the period indicated and is not a regulatory permit or entitlement to do business. There may be additional requirements before the business may be legally conducted. This certificate does not authorize the conduct or continuance of any illegal or unlawful operation in violation of any law or ordinance.

Business: MILITARY MEDICAL SUPPLIES
Address: 1440 S STATE COLLEGE BLVD 5H
Owner / Officer: DAVID SCHEIDT, MEMBER
Corporation / Partnership: WP & H LLC

CITY OF ANAHEIM

Classification 3081B

This certificate is issued without verification that the holder is subject to or exempted from licensing by the state, county, federal government, or any other governmental agency.

Expiration Date 03/15/20

Business License Number BUS2018-03086

Date Issued 10/05/18

Type of Business SALES & RENTAL OF DURABLE MEDICAL EQUIPMENT (MEDICAL MARIJUANA PROHIBITED)

To: MILITARY MEDICAL SUPPLIES
1440 S STATE COLLEGE BLVD 5H
ANAHEIM, CA 92806 0000

"Under federal and state law, compliance with disability access laws is a serious and significant responsibility that applies to all California building owners and tenants with buildings open to the public. You may obtain information about your legal obligations and how to comply with disability access laws at the following agencies:
The Division of the State Architect at www.dgs.ca.gov/dsa/Home.aspx.
The Department of Rehabilitation at www.rehab.cahwnet.gov.
The California Commission on Disability Access at www.ccda.ca.gov."

BUSINESS START DATE: 03/25/2002

L1865294336
FORM G-44A
(REV. 2016)

STATE OF HAWAII
DEPARTMENT OF TAXATION

LICENSE ISSUED FOR THE PRIVILEGE OF ENGAGING IN BUSINESS AND OTHER ACTIVITIES UPON THE CONDITION THAT THE LICENSEE SHALL PAY THE TAXES ACCRUING TO THE STATE OF HAWAII UNDER THE PROVISIONS OF CHAPTER 237, HRS, AS AMENDED. LICENSEE'S ACTIVITIES ARE LISTED ON THE APPLICATION ON FILE WITH THE DIRECTOR OF TAXATION.

GENERAL EXCISE TAX LICENSE

THIS LICENSE IS NOT TRANSFERABLE.
TO BE DISPLAYED CONSPICUOUSLY AT THE PLACE OF BUSINESS FOR WHICH ISSUED.

HAWAII TAX ID NUMBER: GE-016-154-0096-01
WP&H, LLC
DBA CALMED HAWAII
2850 PAA ST
STE 110A
HONOLULU HI 96819-4457

Re: License Letter

STATE OF CALIFORNIA

DEPARTMENT OF PUBLIC HEALTH
FOOD AND DRUG BRANCH

HOME MEDICAL DEVICE RETAIL LICENSE

WP&H, LLC
DBA: Military Medical Supplies
1440 S. State College Boulevard, Suite - 5H
Anaheim, CA 92806

LICENSE NUMBER: 52978
EXPIRATION DATE: 12/30/2020

Instate Retail Firm

The person named herein is licensed to operate a Home Medical Device Retail Facility through the expiration date of this license. This annual 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 shall be responsible for assuring compliance with all requirements of this article pertaining to Home Medical Device Retail Facilities.

Food and Drug Branch, 1500 Capitol Avenue, MS 7602, PO Box 997435, Sacramento, CA 95899-7435 (916) 650-6500

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: Royal Biologics, Inc

Physical Address: 401 Hackensack Ave, Suite 604, Hackensack NJ 07601
(This must be a business address, we cannot issue a license to a home address)

Mailing Address: 401 Hackensack Ave, Suite 604

City: Hackensack State: NJ Zip Code: 07601

Telephone: 201-488-1549 Fax: 270-721-6932

E-mail: adam@royalbiologics.com Website: RoyalBiologics.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:30am to 4:30pm Tue: 8:30am to 4:30pm Wed: 8:30am to 4:30pm Thu: 8:30am to 4:30pm Fri: 8:30am to 4:30pm Sat: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Salvatore Leo

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: Bone marrow Aspiration needles, Platlet Rich Plasma ki

**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 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.

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

Adam Ferretti
Print Name of Authorized Person

04 Dec 2019
Date

Board Use Only	Received: FEB 05 2020	Amount: 500.00

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: New York

Parent Company if any: AR orthopedic Holdings, LLC

Corporation Name: Royal Biologics, Inc

Mailing Address: 401 Hackensack Ave, suite 604

City: Hackensack State: NJ Zip: 07601

Telephone: 201-488-1549 Fax: 270-721-6932

Contact Person: Adam Ferretti

For any corporation non-publicly traded, disclose the following:

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

a) Salvatore Leo, Campo Sano Ave, Miami FL 33146
Name Address

b) Demetri Soteropoulos, 1st Ave, New York, NY 10022
Name Address

c) Granite Creek FlexCap II, L.P. W Adams St, suite , Chicago, IL 60606
Name Address

d) Wayne Homschek, 5th Ave, New York, NY 10017
Name Address

2) Provide the number of shares issued by the corporation. 83.18 units

3) What was the price paid per share? N/A Traded for equity.

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.

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF REVENUE AND ENTERPRISE SERVICES
ANNUAL REPORT CERTIFICATE

ROYAL BIOLOGICS INC.
0450132116

The Division of Revenue and Enterprise Services hereby affirms that the following annual report for ROYAL BIOLOGICS INC. was submitted on 08/16/2019 for the year: 2019

Registered Agent and Office

SALVATORE LEO
401 Hackensack Ave
Suite 604
Hackensack, NJ 07601

Main Business Address

401 Hackensack Ave
Suite 604
Hackensack, NJ 07601

Principal Business Address

401 Hackensack Ave
Suite 604
Hackensack, NJ 07601

Officers and Directors

CHIEF EXEC. OFFICER (CEO)
SALVATORE LEO
401 Hackensack Ave
Suite 604
Hackensack, NJ 07601

PRESIDENT
DEMETRIOS SOTEROPOULOS
401 Hackensack Ave
Suite 604
Hackensack, NJ 07601

Continued on next page...

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF REVENUE AND ENTERPRISE SERVICES
ANNUAL REPORT CERTIFICATE

ROYAL BIOLOGICS INC.

0450132116

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my Official Seal, this 16th day of August, 2019

Elizabeth Maher Muoio
State Treasurer

Certificate Number : 2421570043
Verify this certificate online at
https://www1.state.nj.us/TYTR_StandingCert/JSP/Verify_Cert.jsp

Royal Biologics, Inc List of Officers and Directors

Salvatore Leo – Chief Executive Officer

Demetri Soteropoulos – President

Jennifer Hoeffler – VP of Operations

Adam Ferretti – Director of Quality

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/19/2019

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	CONTACT NAME:	
HAUSER 5905 E. Galbraith Rd, Ste 9000 Cincinnati OH 45236	PHONE (A/C, No, Ext): 513-936-7386	FAX (A/C, No): 513-984-7086
	E-MAIL ADDRESS: lwillis@thehausergroup.com	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : CNA Insurance Companies	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED ROYABIO-01
Royal Biologics Inc.
Alpha Spine Corp.
AR Orthopedic Holdings, LLC
401 Hackensack Avenue Suite 604
Hackensack NJ 07601

COVERAGES **CERTIFICATE NUMBER: 1158835492** **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:			6025089857	1/15/2019	1/15/2020	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 $ 300,000 $ 10,000 $ 2,000,000 $ 4,000,000 $ Excluded $
A	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			6025089857	1/15/2019	1/15/2020	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ 1,000,000 $ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE $	$ $ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					[ ] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A	Products Liability			ADT 6076090275	1/15/2019	1/15/2020	Per Occurrence Aggregate	$5,000,000 $5,000,000

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

CERTIFICATE HOLDER

For Informational Purposes Only

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

D.M. Worrall

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
☐ 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: Sleep Management, L.L.C.

Physical Address: 11801 North Tatum Blvd., Suite 140, Phoenix, AZ 85028
(This must be a business address, we cannot issue a license to a home address)

Mailing Address: 625 E. Kaliste Saloom Road

City: Lafayette State: LA Zip Code: 70508

Telephone: (337) 504-3802 Fax: (337) 504-4409

E-mail: bstoute@viemed.com Website: www.viemed.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 4pm Tue: 9am to 4pm Wed: 9am to 4pm Thu: 9am to 4pm Fri: 9am to 4pm Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Richard Kovacik

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: Annie Taylor, RRT Telephone: 702-321-9269

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.

Daniel B Stoute

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

Daniel Brett Stoute

Print Name of Authorized Person

01/27/2020

Date

Board Use Only	Received: 2-10-2020	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: Sleep Management, LLC

Mailing Address: 625 E. Kaliste Saloom Road

City: Lafayette State: Louisiana Zip: 70508

Telephone: 337-504-3802 Fax: 337-504-4409

Contact Person: Brett Stoute

For any corporation non-publicly traded, disclose the following:

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

a) _____
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

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) 1/29/2020

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

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer 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
INSURER B : Travelers Indemnity Co of CT	25682
INSURER C : Travelers Indemnity Company	25658
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Viemed, Inc., Sleep Management, LLC dba
VieMed, Home Sleep Delivered, LLC
202-A N. Luke Street
Lafayette, LA 70506

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			UB1L76006A19I2G	08/01/2019	08/01/2020	X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N: 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	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

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy
Suite 206
Reno, NV 89521

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

KLEBL

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

SLEEP MANAGEMENT, L.L.C.

A limited liability company domiciled in LAFAYETTE, LOUISIANA,

Filed charter and qualified to do business in this State on July 07, 2006,

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,

January 29, 2020

Secretary of State

Web 36222810K

STATE OF LOUISIANA · UNION · JUSTICE · CONFIDENCE · SECRETARY OF STATE

Certificate ID: 11163203#3CF52

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

4Y

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: RedHill Biopharma, Inc.

Physical Address: 8045 Arco Corporate Drive, Suite 200

City: Raleigh State: NC Zip Code: 27617

Telephone Number: (984) 444-7010 Fax Number: (984) 538-0422

Toll Free Number: (844) 786-9559

E-mail: REL@slsny.com Website: www.redhillbio.com

Facility Manager: Craig Robert Miller

Professional qualifications and experience of facility manager: Hire, train, manage and evaluate the performance of assigned warehouse employees; assign workloads to warehouse workers. Effectively manage orders, adhering to quality and safety standards.Management of the home office and the secure warehouse.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers

☒ Other: Distributors

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) Labeler Code: 57841

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: Cosmo S.P.A
Address: Lainate, Milan, Italy

Name:
Address:

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

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

Craig Robert Miller
Print Name of Authorized Person

12.5.2019
Date

Board Use Only	Date Processed: 2-10-2020	Amount: 500 —

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DE

Parent Company if any: RedHill Biopharma Ltd

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) RedHill Biopharma Ltd — 21 HaArba's Street Tel Aviv, Israel 6473921
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% Owned by RedHill Biopharma Ltd

3) What was the price paid per share? 100% Sole Owner - No Shares Issued

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 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.

RedHill Biopharma, Inc.

Corporate Address: 8045 Arco Corporate Drive, Suite 200, Raleigh, NC 27617 USA
FEIN: 81-5095681
www.redhillbio.com

Drug Labeler Code: 57841
Incorporation State: DE
Incorporation Date: 1/19/2017

FACILITY INFORMATION

Code	Address	FDA	DEA	DUNS	VAWD	Phone	Fax
200	8045 Arco Corporate Drive Suite 200 Raleigh, NC 27617 County: Wake County	N/A	N/A - No CS	080638524	No	(984) 444-7010	(984) 538-0422

FACILITY DESIGNATED REPRESENTATIVES

Name	Address	Title	Prescribing Authority
Craig Robert Miller	Colin Hill Ct. Wake Forest, NC 27587-8074	VP, Trade Relations	No

OWNERSHIP

Name	Address	Title	Percent of Ownership	Prescribing Authority
RedHill Biopharma Ltd	2 HaArba's Street Tel Aviv, 6473921 Israel		100	

LIST OF OFFICERS

Name	Address	Title	Prescribing Authority
David Kai Wasserman	1 N Frank Lloyd Wright Blvd. #1084 Scottsdale, AZ 85260	VP of Compliance	No
Craig Robert Miller	Colin Hill Ct. Wake Forest, NC 27587-8074	VP, Trade Relations	No

REGISTERED AGENT IN ALL APPLICABLE STATES

Name
Incorp Services

3PLS

Name	Address	Title	Prescribing Authority
Eversana Life Science Services LLC	4580 Mendenhall Road Memphis, TN 38141		

2020

NOT TRANSFERABLE
STATUTE GS 81.106.119

North Carolina Department of Agriculture & Consumer Services
Steve Troxler, Commissioner
Food and Drug Protection Division

LICENSE/CERTIFICATE NO.
506

LICENSE/CERTIFICATE: Virtual Manufacturer
TYPE

Expiration Date 12/31/2020

LICENSEE OR CERTIFICATOR
RedHill Biopharma, Inc.
8045 Arco Corporate Drive, Ste 200
Raleigh NC 27617

LICENSED
2020
NORTH CAROLINA

THIS LICENSE/CERTIFICATE MAY BE SUBJECT TO REVOCATION OR SUSPENSION AS PROVIDED BY LAW

STEVE TROXLER, COMMISSIONER

Home Stay

RedHill Biopharma

01/23/2020

To State licensing,

RedHill Biopharma, Ltd., with DUNS# 533278342 has already been assigned Labeler Code 57841. Please note that the FDA has given guidance that the same labeler code can be used for multiple sites if they are under one company (parent, subsidiary, and/or affiliate). In this case, RedHill Biopharma, Inc. with DUNS# 080638524 is a wholly owned subsidiary of RedHill Biopharma, Ltd., and thus qualifies to use Labeler Code 57841.

The Labeler Code belongs to the company that owns the brand or NDA, which RedHill Biopharma Ltd. does in the case of Talicia. If the company has multiple sites, each site must have its own DUNS number, but may operate under the same Labeler Code. Just to clarify, DUNS are site-specific and labeler codes are company-specific.

Best regards,

Craig Miller

Craig Miller
Vice President, Trade Channel
RedHill Biopharma, Inc.

REDHILL BIOPHARMA, INC.
8045 ARCO CORPORATE DRIVE
SUITE 200
RALEIGH, NC 27617
984-444-7010
WWW.REDHILLBIO.COM

From: Reggie Williams (Quality)
To: Reggie Williams (Quality)
Subject: RE: New Labeller code requried for the new product RedHill
Date: Friday, January 17, 2020 12:46:00 PM
Attachments: image001.png

Hi Pat,

FDA does not issue site-specific labeler codes anymore. They now want companies to use the same labeler code for multiple sites, subsidiaries, etc.

[Company] with DUNS [xxx] has already been assigned Labeler Code [12345].
Please note that the same labeler code can be used for multiple sites if they are under one company (parent, subsidiary, and/or affiliate). The labeler is usually the company that owns the brand, and the company most likely associated with the LC. If the company has multiple sites, each site must have its own DUNS and FEI number, but may operate under the same Labeler Code (LC). Just to clarify, DUNS and FEI are site-specific and labeler codes are company-specific.

It is acceptable to have the labeler code under the parent company (Ltd.) and market products using Inc.

Regards,
Jordan

Reggie Williams, CQA, CQM/OE
Vice President, Quality
RedHill Biopharma
8045 Arco Corporate Drive, Suite 200
Raleigh, NC 27617
Office: 984-238-2531
Cell: 919-723-7631
rwilliams@redhillus.com

www.redhillbio.com

RedHill Biopharma

From: Patricia Anderson <patricia@redhillbio.com>
Sent: Thursday, January 16, 2020 1:28 PM
To: Reggie Williams (Quality) <rwilliams@RedHillus.com>

fda.gov/industry/structured-product-labeling-resources/ndc/nhric-labeler-codes

An official website of the United States government Here's how you know

U.S. FOOD & DRUG ADMINISTRATION

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Home / For Industry / FDA Resources for Data Standards / Structured Product Labeling Resources / NDC/NHRIC Labeler Codes

NDC/NHRIC Labeler Codes

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Structured Product Labeling Resources

- Business Entity Identifiers
- Business Operation
- Business Operation Qualifier
- Code System Object Identifiers
- Combination Product Types
- Contributing Factor - General
- Document Type including Content of Labeling Type
- Dosage Forms

Ele

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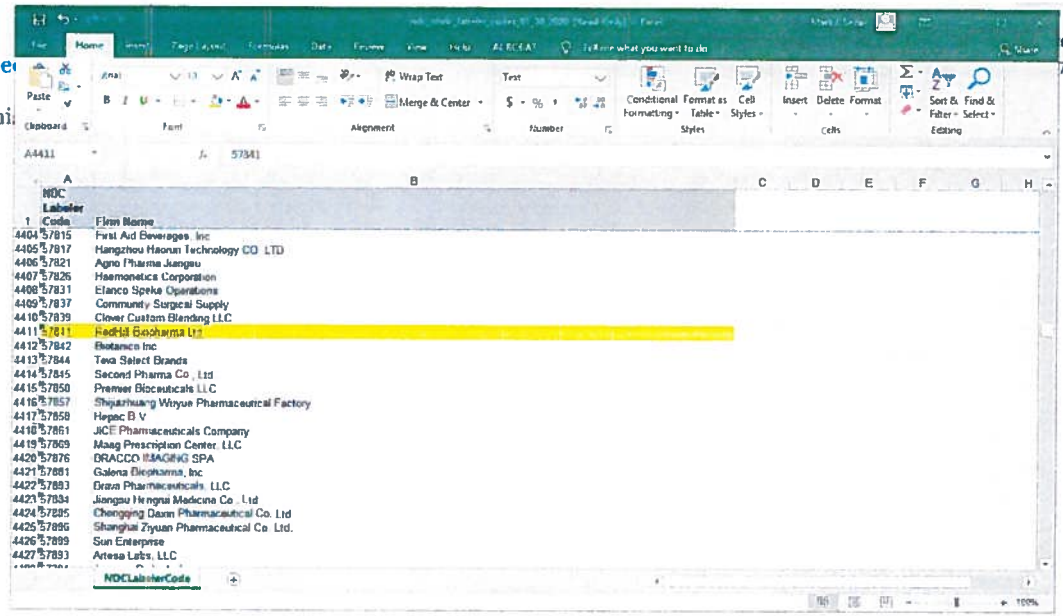
ent current as of:
7/2018

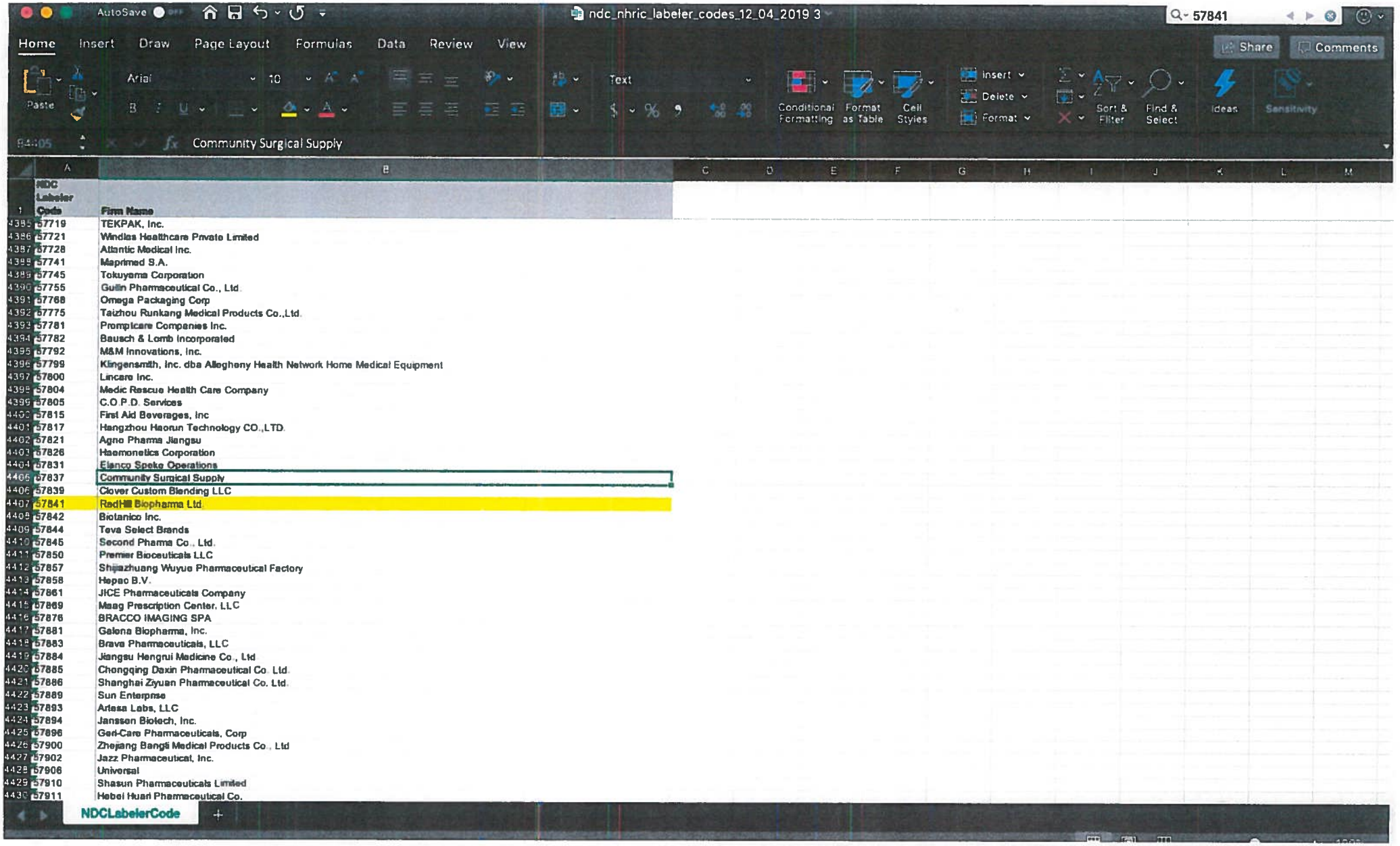


	NDC Labeler Code	Firm Name
4404	57815	First Aid Beverages, Inc
4405	57817	Hangzhou Haorun Technology CO. LTD
4406	57821	Agno Pharma Jiangsu
4407	57826	Haemonetics Corporation
4408	57831	Eranco Speke Operations
4409	57837	Community Surgical Supply
4410	57839	Clover Custom Blending LLC
4411	57841	Fedrid Biopharma Ltd
4412	57842	Botanico Inc
4413	57844	Teva Select Brands
4414	57845	Second Pharma Co., Ltd
4415	57850	Premier Bioceuticals LLC
4416	57857	Shijiazhuang Wiyue Pharmaceutical Factory
4417	57858	Hepac B.V.
4418	57861	JCE Pharmaceuticals Company
4419	57869	Maag Prescription Center, LLC
4420	57876	BRACCO IMAGING SPA
4421	57881	Galena Biopharma, Inc
4422	57883	Bravo Pharmaceuticals, LLC
4423	57884	Jiangsu Hengrui Medicine Co., Ltd
4424	57895	Chongqing Daxin Pharmaceutical Co. Ltd
4425	57896	Shanghai Ziyuan Pharmaceutical Co. Ltd.
4426	57899	Sun Enterprise
4427	57893	Artesa Labs, LLC

NDCLabelerCode

Verified DZ 1/30/2020

ndc_nhric_labeler_c....zip ndc_nhric_labeler_c....zip ndc_nhric_labeler_c....zip



	A	B
1	NDC Labeler Code	Firm Name
4385	57719	TEKPAK, Inc.
4386	57721	Windlas Healthcare Private Limited
4387	57728	Atlantic Medical Inc.
4388	57741	Maprimed S.A.
4389	57745	Tokuyama Corporation
4390	57755	Gulin Pharmaceutical Co., Ltd.
4391	57768	Omega Packaging Corp
4392	57775	Taizhou Runkang Medical Products Co.,Ltd.
4393	57781	Promplcare Companies Inc.
4394	57782	Bausch & Lomb Incorporated
4395	57792	M&M Innovations, Inc.
4396	57799	Klingensmith, Inc. dba Allegheny Health Network Home Medical Equipment
4397	57800	Lincare Inc.
4398	57804	Medic Rescue Health Care Company
4399	57805	C.O.P.D. Services
4400	57815	First Aid Beverages, Inc
4401	57817	Hangzhou Haorun Technology CO.,LTD.
4402	57821	Agno Pharma Jiangsu
4403	57826	Haemonetics Corporation
4404	57831	Elanco Speke Operations
4406	57837	Community Surgical Supply
4406	57839	Clover Custom Blending LLC
4407	57841	RedHill Biopharma Ltd.
4408	57842	Biotanico Inc.
4409	57844	Teva Select Brands
4410	57845	Second Pharma Co., Ltd.
4411	57850	Premier Bioceuticals LLC
4412	57857	Shijiazhuang Wuyue Pharmaceutical Factory
4413	57858	Hepac B.V.
4414	57861	JICE Pharmaceuticals Company
4415	57869	Maag Prescription Center, LLC
4416	57876	BRACCO IMAGING SPA
4417	57881	Galena Biopharma, Inc.
4418	57883	Brava Pharmaceuticals, LLC
4419	57884	Jiangsu Hengrui Medicine Co., Ltd
4420	57885	Chongqing Daxin Pharmaceutical Co. Ltd.
4421	57886	Shanghai Ziyuan Pharmaceutical Co. Ltd.
4422	57889	Sun Enterprise
4423	57893	Artesa Labs, LLC
4424	57894	Janssen Biotech, Inc.
4425	57896	Geri-Care Pharmaceuticals, Corp
4426	57900	Zhejiang Bangti Medical Products Co., Ltd
4427	57902	Jazz Pharmaceutical, Inc.
4428	57906	Universal
4429	57910	Shasun Pharmaceuticals Limited
4430	57911	Hebei Huari Pharmaceutical Co.

Proof of Labeler Code

Good Standing

NORTH CAROLINA
Department of the Secretary of State

CERTIFICATE OF AUTHORIZATION

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

REDHILL BIOPHARMA INC.

a corporation organized under the laws of Delaware was authorized to transact business in the State of North Carolina by issuance of a certificate of authority on the 25th day of January, 2017.

I FURTHER certify that the said corporation's certificate of authority is not suspended for failure to comply with the Revenue Act of the State of North Carolina; that the said corporation's certificate of authority is not revoked for failure to comply with the provisions of the North Carolina Business Corporation Act; that its most recent annual report required by G.S. 55-16-22 has been delivered to the Secretary of State; and that a certificate of withdrawal has not been issued in the name of the said corporation as of the date of this certificate.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at the City of Raleigh, this 5th day of December, 2019.

Elaine F. Marshall

Secretary of State

Scan to verify online.

Certification# 105901272-1 Reference# 15704017- Page: 1 of 1
Verify this certificate online at http://www.sosnc.gov/verification

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. 0766231

Application/License No. LICENSE APPLIED FOR

REDHILL BIOPHARMA, INC., doing or intending to do business as a
Applicant/Principal
pharmaceutical wholesaler, whose address for purposes of service is
8045 ARCO CORPORATE DRIVE, SUITE 200, RALEIGH, NC 27617, as
Address of Applicant/Principal
PRINCIPAL, and INTERNATIONAL FIDELITY INSURANCE COMPANY, a
Surety Company
corporation organized under the laws of the state of NEW JERSEY
State of Incorporation
and authorized to transact a general surety business in the State of

Nevada, whose address for purposes of service is
ONE NEWARK CENTER, 20TH FLOOR, NEWARK, NJ 07102 as
Address of Surety
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 28TH day of AUGUST, 2019.

APPLICANT/PRINCIPAL
REDHILL BIOPHARMA, INC.

Authorized Representative

SURETY COMPANY
INTERNATIONAL FIDELITY INSURANCE COMPANY

Surety Company's Representative

DAVID C. JOSEPH, 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

POWER OF ATTORNEY

Bond # 0769220

INTERNATIONAL FIDELITY INSURANCE COMPANY

ALLEGHENY CASUALTY COMPANY

One Newark Center, 20th Floor, Newark, New Jersey 07102-5207 PHONE (973) 624-7200

KNOW ALL MEN BY THESE PRESENTS. That **INTERNATIONAL FIDELITY INSURANCE COMPANY**, a corporation organized and existing under the laws of the State of New Jersey, and **ALLEGHENY CASUALTY COMPANY** a corporation organized and existing under the laws of the State of New Jersey, having their principal office in the City of Newark, New Jersey, do hereby constitute and appoint

LINDA C. SHEFFIELD, CONWAY C. MARSHALL, STEPHEN BEAHM, DAVID C. JOSEPH, JESSICA PALMERI, MARGARET SCHATZMAN, ROXANNE CRAVEN, ANDREA BECKER, CLARK P. FITZ-HUGH, DARLENE A. BORNT, CATHERINE C. KEHOE, KRISTINE DONOVAN, ELIZABETH W. KEARNEY

New Orleans, LA

their true and lawful attorney(s)-in-fact to execute, seal and deliver for and on its behalf as surety, any and all bonds and undertakings, contracts of indemnity and other writings obligatory in the nature thereof, which are or may be allowed, required or permitted by law, statute, rule, regulation, contract or otherwise, and the execution of such instrument(s) in pursuance of these presents, shall be as binding upon the said **INTERNATIONAL FIDELITY INSURANCE COMPANY and ALLEGHENY CASUALTY COMPANY**, as fully and amply, to all intents and purposes, as if the same had been duly executed and acknowledged by their regularly elected officers at their principal offices.

This Power of Attorney is executed, and may be revoked, pursuant to and by authority of the By-Laws of **INTERNATIONAL FIDELITY INSURANCE COMPANY and ALLEGHENY CASUALTY COMPANY** and is granted under and by authority of the following resolution adopted by the Board of Directors of **INTERNATIONAL FIDELITY INSURANCE COMPANY** at a meeting duly held on the 20th day of July, 2010 and by the Board of Directors of **ALLEGHENY CASUALTY COMPANY** at a meeting duly held on the 10th day of July, 2015 :

"**RESOLVED**, that (1) the Chief Executive Officer, President, Executive Vice President, Vice President, or Secretary of the Corporation shall have the power to appoint, and to revoke the appointments of, Attorneys-in-Fact or agents with power and authority as defined or limited in their respective powers of attorney, and to execute on behalf of the Corporation and affix the Corporation's seal thereto, bonds, undertakings, recognizances, contracts of indemnity and other written obligations in the nature thereof or related thereto; and (2) any such Officers of the Corporation may appoint and revoke the appointments of joint-control custodians, agents for acceptance of process, and Attorneys-in-fact with authority to execute waivers and consents on behalf of the Corporation, and (3) the signature of any such Officer of the Corporation and the Corporation'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 seals when so used whether heretofore or hereafter, being hereby adopted by the Corporation as the original signature of such officer and the original seal of the Corporation, to be valid and binding upon the Corporation with the same force and effect as though manually affixed."

IN WITNESS WHEREOF, **INTERNATIONAL FIDELITY INSURANCE COMPANY** and **ALLEGHENY CASUALTY COMPANY** have each executed and attested these presents on this 31st day of December, 2016

INTERNATIONAL FIDELITY INSURANCE COMPANY CORPORATE SEAL 1904 NEW JERSEY

STATE OF NEW JERSEY
County of Essex

George R. James
Executive Vice President (International Fidelity Insurance Company) and
Vice President (Allegheny Casualty Company)

ALLEGHENY CASUALTY COMPANY 1936 NEW JERSEY

On this 31st day of December, 2016 before me came the individual who executed the preceding instrument, to me personally known, and, being by me duly sworn, said he is the therein described and authorized officer of **INTERNATIONAL FIDELITY INSURANCE COMPANY and of ALLEGHENY CASUALTY COMPANY**, that the seals affixed to said instrument are the Corporate Seals of said Companies; that the said Corporate Seals and his signature were duly affixed by order of the Boards of Directors of said Companies.

CATHY CRUZ NOTARY PUBLIC COMMISSION EXPIRES MY 04-16-2019 STATE OF NEW JERSEY

IN TESTIMONY WHEREOF, I have hereunto set my hand affixed my Official Seal, at the City of Newark, New Jersey the day and year first above written.

Cathy Cruz a Notary Public of New Jersey
My Commission Expires April 16, 2019

CERTIFICATION

I, the undersigned officer of **INTERNATIONAL FIDELITY INSURANCE COMPANY** and **ALLEGHENY CASUALTY COMPANY** do hereby certify that I have compared the foregoing copy of the Power of Attorney and affidavit, and the copy of the Sections of the By-Laws of said Companies as set forth in said Power of Attorney, with the originals on file in the home of said companies, and that the same are correct transcripts thereof, and of the whole of the said originals, and that the said Power of Attorney has not been revoked and is now in full force and effect.

IN TESTIMONY WHEREOF, I have hereunto set my hand on this day, August 28, 2019

A00586 International Sureties Ltd

4Z

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: Kaiser Foundation Hospitals

Physical Address: 5800 Coliseum Way

City: Oakland , CA State: CA Zip Code: 94621 Telephone

Number: 510-434-5858 Fax Number: 510-434-5804

Toll Free Number: N/A

E-mail: perry.lau@kp.org Website: healthy.kaiserpermanente.org

Facility Manager: Perry Lau

Professional qualifications and experience of facility manager: Over 15 years of experience in wholesale distribution and facility management. 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 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: Hikma Pharmaceutical
Address: 401 Industrial Way West, Eatontown, NJ 207724

Name: Glaxo Smithkline
Address: One Franklin Plaza, Philadelphia, PA 19102

Name: Eli Lilly & Co
Address: 916 Mutal Savings Building, Pasadena, CA 91101

Name: Sandoz, Inc.
Address: 2555 West Midway Blvd., Broomfield, CA 80020

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.

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

Troy Smith
Print Name of Authorized Person

11/12/2019
Date

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

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DE

Parent Company if any: N/A

Mailing Address: 5800 Coliseum Way

City: Oakland State: CA Zip: 94621

Telephone: 510-434-5858 Fax: 510-434-5804

Contact Person: Perry Lau

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 - Registered as a non-profit public benefit corporation. No owners/members.
Name Business Address

b) N/A
Name Business Address

c) N/A
Name Business Address

d) N/A
Name Business Address

2) Provide the number of shares issued by the corporation. 0

3) What was the price paid per share? 0

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 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.

Kaiser Foundation Hospitals, Inc.
List of Officers

Corporate Officers	Office Address
Troy Smith, Executive Director, National Warehousing and Logistics	1 E. Walnut Street Pasadena, CA 91188
Joseph Montero, Assistant Director, Pharmacy Materials Services	Dalen Street Downey, CA 90242

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:

KAISER FOUNDATION HOSPITALS

FILE NUMBER:	C0224971
FORMATION DATE:	02/20/1948
TYPE:	DOMESTIC NONPROFIT 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 December 31, 2019.

ALEX PADILLA
Secretary of State

DLS

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:

KAISER FOUNDATION HOSPITALS

FILE NUMBER:	C0224971
FORMATION DATE:	02/20/1948
TYPE:	DOMESTIC NONPROFIT 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 June 21, 2019.

ALEX PADILLA
Secretary of State

NP-25 (REV 02/2019)

JJG

Renewal License

Wholesale Drug Permit

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

LICENSE NO. WLS 4130
RECEIPT NO. 90790475

VALID UNTIL MAY 01, 2020

KAISER FOUNDATION HOSPITALS
5800 COLISEUM WAY
OAKLAND CA 94621

In accordance with the provisions of section 4160 of the Business and Professions Code, the firm name hereon is issued a Wholesale Drug Permit.

This permit is non-transferable. Contact the California State Board of Pharmacy within 30 days when there is a change of ownership, location, corporate officer, director, shareholder (more than 10 percent share change) manager, vice president of operations, or designated representative-in-charge.

This permit is valid only at the address shown.

03/22/19

03/22/19 The official status of this license can be verified at www.pharmacy.ca.gov

----- NON-TRANSFERABLE --- POST IN PUBLIC VIEW -----

FORM WPHWLS (12/31/05) W

Verified 12/30/14 DZ

The National Association of Boards of Pharmacy®

hereby awards

Verified-Accredited Wholesale Distributors®

Accreditation

to

Kaiser Foundation Hospitals

located at

5800 Coliseum Way, Oakland, CA 94621

This facility has met all the Verified-Accredited Wholesale Distributors (VAWD) criteria set in place by the National Association of Boards of Pharmacy. The current status of this facility's accreditation may also be verified by visiting the VAWD section of the NABP website, located at www.nabp.pharmacy.

Carmen A. Catizone, Executive Director/Secretary

October 7, 2018 - October 6, 2021

Period of Accreditation

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206
Reno, NV 89521
(775) 850-1440
Fax: (775) 850-1444

PHARMACEUTICAL WHOLESALER SURETY BOND

Bond No. 070209564

Application/License No. N/A

KAISER FOUNDATION HOSPITALS (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is 5800 Coliseum Way Oakland, CA 94621 (Address of Applicant/Principal), as PRINCIPAL, and LIBERTY MUTUAL INSURANCE COMPANY (Surety Company), a corporation organized under the laws of the state of Massachusetts (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is 175 Berkeley Street, Boston MA 02116 (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 TWENTY-FIVE THOUSAND DOLLARS ($25,000.00), 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 01/06/2020 (Effective Date).

WHEREAS, the provisions of Nevada Revised Statue (NRS) 639.515 and Nevada Administrative Code (NAC) 639.5937 require that the Applicant/Principal file or have on file with the Nevada State Board of Pharmacy (Board) a bond in the sum of $25,000.00 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 NAC 639.5937 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 and NAC 639.5937. 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 6th day of January, 20 20.

APPLICANT/PRINCIPAL

COMPANY
KAISER FOUNDATION HOSPITALS

Authorized Representative

SURETY
LIBERTY MUTUAL INSURANCE COMPANY

Surety Company's Representative

Marina Tapia, Attorney-in-fact
print name

SIGNED and SEALED in the presence of:

Witness

Witness

SIGNED and SEALED in the presence of:

Witness Donna Garcia

Witness Samantha Fazzini

Countersigned by:

Nevada Resident Agent
Marina Betsy Tapia
Non-Resident Producer
License No.: 884868

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

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 Los Angeles

On JAN 06 2020 before me, Meghan Hanes, Notary Public, personally appeared Marina Tapia who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is/~~are~~ subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature~~(s)~~ on the instrument the person~~(s)~~, or the entity upon behalf of which the person~~(s)~~ acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

Liberty Mutual SURETY

This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Certificate No: 8198054-024029

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, B. Aleman, Tracy Aston, Thomas Branigan, Lisa K. Crail, Ashraf Elmasry, Samantha Fazzini, Donna Garcia, Simone Gerhard, April Martinez, Rosa E. Rivas, Paul Rodriguez, Edward C. Spector, Marina Tapia, Nathan Varnold, KD Wapato

all of the city of Los Angeles state of California each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 28th day of November, 2018.

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

State of PENNSYLVANIA
County of MONTGOMERY ss

On this 28th day of November, 2018 before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute 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 have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS: Section 12. Power of Attorney.
Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts: Section 5. Surety Bonds and Undertakings.
Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this _____ day of JAN 06 2020

By: _____
Renee C. Llewellyn, Assistant Secretary

LMS-12873 LMIC OCIC WAIC Multi Co_062018

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

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 Alameda)

On January 9, 2020 before me, Colleen Dahle-Hong, Notary Public,
Date *Here Insert Name and Title of the Officer*

personally appeared David Bell
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

COLLEEN DAHLE-HONG
Commission No. 2207081
NOTARY PUBLIC-CALIFORNIA
ALAMEDA COUNTY
My Comm. Expires AUGUST 22, 2021

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature Colleen Dahle-Hong
Signature of Notary Public

Place Notary Seal Above

OPTIONAL

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document Nevada State Board of Pharmacy
Title or Type of Document: Pharmaceutical Wholesaler Surety Bond
Document Date: Effective on 01/06/2020 Number of Pages:
Signer(s) Other Than Named Above: No other signer

Capacity(ies) Claimed by Signer(s)

Signer's Name: David Bell	Signer's Name:
☐ Corporate Officer — Title(s):	☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☐ General
☐ Individual ☐ Attorney in Fact	☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian or Conservator	☐ Trustee ☐ Guardian or Conservator
☐ Other:	☐ Other:
Signer Is Representing: KFH	Signer Is Representing:

Perry Lau, Pharm. D, MCSE

MCP ID#1858399

Pharmacy Distribution Center Manager
Oakland Pharmacy Distribution Center
California Pharmacy Materials Services
5800 Coliseum Way
Oakland CA 94621
510-434-5858 (Oakland Office)
8-498-5858
925-294-5560 (Livermore Office)
8-453-5560
E-mail:Perry.Lau@kp.org

Pharmacy Experience

9/09 to Present
Pharmacy Distribution Center Manager
Oakland Pharmacy Distribution Center
Pharmacy Repack Center

Main Responsibility

- Responsible to provide pharmaceutical product and supply distribution service to Northern California Pharmacies, Southern California Downey Distribution Center, National Specialty Drug Pharmacy Program, all Distribution Centers and Pharmacies for Regions Outside of California. OPDC also provide Drug Wholesaler service to Group Health in Seattle Washington, a Non-Kaiser Health Care Partner.
- Lead a high performance operation team consisted of one BOP Licensed Assistant Manager, four BOP Licensed Production Supervisors, one Customer Service Supervisor, two Procurement Specialty Pharmacists, more than 50 Warehousemen, 12 Pharmacy Department Clerks and Procurement Specialists. Operation hours are from 7AM to 2:30AM Sunday to Thursday.
- OPDC maintains in average of $200 to $240 Million Pharmacy Inventory as of 2013.
- OPDC completed annual physical inventory in 2009 with variances of -$345.97, in 2010 with variances of -$345.97 and in 2012 with variances of +$25.11.
- OPDC shipped and received drug products for $40 to $50 Million monthly in 2012.
- Significant reduction of NCAL Pharmacy and Clinic order claims from 2009 of 0.081% to 2012 of 0.040%.
- Significant reduction of Out of Region Pharmacy and Distribution Centers order claims from 2009 of 0.34% to 2012 of 0.17%.
- OPDC is Board of Pharmacy licensed for California, Oregon, Washington State, Colorado, Mid Atlantic, Hawaii and a Non-Kaiser Health Care Partner, Group Health in Seattle Washington.
- Since 2009, OPDC completed many regulatory visits and inspections including FDA, DEA, OSHA, various State and County inspections with no major deficiencies. Many internal and external SOX audits were also performed with no major deficiencies or recommendation. OPDC completed quarterly internal pharmacy audits with no major deficiencies since 2009. OPDC received full Accreditation of VAWD (Verified-Accredited Wholesaler Distributors) from National Association of Boards of Pharmacy in 2010 which recognized Drug Distribution Centers to meet and exceed Federal and State regulatory compliance standards. We are currently in a process to renew our VAWD as required every 3 years.
- Responsible to monitor local Medical Center Pharmacy and Clinic GRX drug returns and appropriate recharges and credits are completed on time.
- Significant improvement of People Pulse Survey from ~60% in 2009 to ~80% in 2012.

Additional Responsibility – Pharmacy Repack

- Responsible to ensure Kaiser National Drug Repackaging Department to align with National Pharmaceutical Contracting and Strategies for drug contracting programs. Provide service support and product demands for NCAL Outpatient, Inpatient, Consolidated Prescription Pharmacy Service, facility with Local Automation, SCAL Downey Distribution Center and Out of Region Pharmacies.
- Pharmacy Repack maintains Kaiser FDA drug labeler codes and NDC registration, issues unique NDCs for internal produced drug products and products produced by our external contracted repackagers. All contracted repackagers are inspected and audited regularly by Repack Pharmacy Management Team to ensure FDA, DEA and cGMP compliance.
- Pharmacy Repack product catalog includes drug package sizes not available commercially in Outpatient setting, solid and liquid unit dose for Inpatient setting and reverse bulking service for CPP and Facilities with Local Automation. Annual production is between 4 to 5 Million packaging units as of 2012.
- Operations consist of One Repack Manager, One Quality Assurance Pharmacist; two BOP licensed Production Supervisors, One Department Clerk and 20+ Repackagers.
- Pharmacy Repack is CDPH licensed, FDA and DEA registered drug repackaging facility. Since 2006, both FDA and DEA have routinely visited Pharmacy Repack for inspection with no citations or any major deficiencies.
- Pharmacy Repack completed the Regional Internal Audit in 2009. In additional to meet all business, financial and security compliance, Repack Pharmacy complied with all regulatory requirement including Title 21 CFR 201.11 and cGMP compliance with no deficiency.
- Repack currently has met and exceeded Pharmaceutical Industry World Class Overall Equipment Efficiency (OEE) with more than 40% vs. 35% in the Pharmaceutical Manufacturing Industry.
- Significant improvement of People Pulse Survey from ~78% in 2009 to ~98% in 2012.

9/06 to 9/09
Pharmacy Repack Manager
Livermore Regional Office
(See Above)

4/06 to 8/06
Special Project Manager for National Specialty Drug Pharmacy – Kaiser Daly City Medical Center

- Responsible to lead, design and implement a brand new Specialty Drug Pharmacy in NCAL to currently provide specialty drug service to Kaiser Pharmacies and members nationwide.
- After the project was assigned, Specialty Pharmacy was in operational within only 4 months including pharmacy site selection with TPMG and local Administration support, licensing, workflow and dispensing design, pharmacy system integration, inter-regional accounting setup, product selection planning, service implementation phases, clinical care and drug delivery logistic.
- Responsible to design and implement a new clinical database program which was able to manage confidential patient profile and records, comply with specialty drug FDA and Manufacturer clinical care requirement and risk maps. Worked with IT programmer to complete the database program in 3 months. The database program provided the pathway to Pharmacy Analytical Services for the development of the new Specialty Drug Pharmacy Processing System.
- Developed staffing requirement, hiring of the Pharmacy Manager and supporting staff was completed in 3 months.
- Worked with local Medical Center IT website development team to develop the first Specialty Drug Pharmacy Website using Kaiser Daly City Medical Center Portal.
- Pharmacy officially opened on time as expected in August, 2006.

10/05 to 9/06
CPP Operation Manager – Procurement, Inventory Management and Delivery Services

- Responsible to manage drug inventory procurement and supply, QMSI inventory.
- Responsible to manage drug and expense invoices and timely payment.
- Responsible to work with Pharmacy Finance and Inventory for count preparation, vendor count process and logistic, staffing and completion of the annual physical inventory on time with minimum variances.
- Responsible to manage A Frame, automated dispensing cell replenishment logistic, sorting system, daily pharmacy delivery tasks, common courier and USPS mail order logistic and service.

- Worked with Kaiser Transportation to ensure timely daily RX delivery to all NCAL pharmacies.
- Initiated and implemented new Sunday delivery in 2006.
- Provided support to extend operating hours for 24 hours production service to meet 24 hours order turnaround time expectation for the pharmacies.

10/06 – 10/07
Design and Complete Outpatient Down Time Database Program

- Responsible to develop Northern California PIMS downtime labeling program to minimize Outpatient Pharmacy service interruption during any PIMS system downtime
- Worked with Regional IT to complete the PIMS downtime labeling program packaging process (MWI SAT Tool) to allow a NCAL pharmacy wide implementation with maintenance free operations and minimum IT support.

9/99 – 10/05
Pharmacy Service Manager - Fremont Medical Center

- Managed 5 Outpatient Pharmacies and Hospital Discharge Pharmacy.
- Fremont Pharmacies had consistently provided excellence Pharmacy Service which was demonstrated by the Member Patient Satisfaction Score and Pharmacy Satisfaction Survey.
- Responsible to plan and implement local eRX. Worked closely with local TPMG, Administration and local IT Team to provide eRX training support for Fremont Medical Center care providers.
- Fremont Medical Center was consistently one of the highest eRX utilized Medical Center before the implementation of Health Connect.
- Responsible to develop plan, startup logistic and hiring manager and supporting staff to open Fremont Hospital Inpatient Pharmacy to provide new Inpatient Pharmacy Service in Fremont Medical Center.
- Responsible to plan and implementation of to PC to Fax (Pre-CPOE) ordering system and deployment of Pyxis Medstation and Pandora software.
- Worked with Fremont Hospital Administration to plan and implement after hours Pharmacy Services to ensure maximum patient care and satisfaction.
- Participated as one of the Outpatient Pharmacy Management Approving Committee Members to approve new PIMS system upgrades or releases.
- Managed all Fremont Pharmacy Ambulatory Care Service until the transition of the service management to Pharmacy Clinical Operations Manager.

11/04 – 2009
Regional Pharmacy Managed Workstation Initiative (MWI) Project Manager

- Represented NCAL Pharmacy Division to roll out Managed Workstation Initiative (MWI) for Outpatient, Inpatient and Ambulatory Care Pharmacy NON-PIMS application or programs used for business or operations.
- Responsible to identify and determine if the local pharmacy applications (32 applications) were the candidates or qualified with appropriate conditions to be converted or upgraded in the MWI application database catalog.
- Responsible to approve application conversion and upgrades, determine alternative application for business owners if needed or retired and removed the affected applications from all Kaiser Computer Systems.
- Worked with IT and Contracted Programmers for application conversion, upgrades and UAT to meet Kaiser application system and security standard for long term business use.
- Worked with Regional and local IT to implement updated or new application with minimum or no service impact for the affected pharmacies.

9/00 – 9/01
Fremont Hospital Discharge Pharmacy – New Pharmacy Opening

- Successfully planned and completed all business and regulatory logistics to open New Fremont Discharge Pharmacy to provide discharge pharmacy service for Fremont Hospital patients.

7/99 – 1/00
Interim Pharmacy Service Manager - Hayward Medical Center

- Worked as Interim Pharmacy Service Manager to manage 4 Outpatient Pharmacies, Inpatient Pharmacy and Pharmacy Clinical Services until the hiring of the new Outpatient Pharmacy Service Manager and Inpatient Pharmacy Director.

4/99 – 8/99
Member of Pharmacy Automation (1st Robotic Dispensing) Project Team - Oakland Medical Center

- Responsible to work with project team members to plan, identify requirement and implement a new prescription imaging system (Pharmacy 2000 from McKesson) and automated (Robotic-McKesson) prescription dispensing system in the pilot site.

4/98 – 9/98
Team Member Leader of the California Division Pharmacy Improvement Program Team (PIP)

- Responsible to lead NCAL East Bay PIP Team to implement pharmacy best practices to improve outpatient pharmacy services including waiting time, patient care, customer service, OTC sales, pharmacy inventory and cost effective operations.

12/95 – 9/98
Assistant Pharmacy Service Manager - Oakland Medical Center

- Responsible to Manage Oakland Main Hospital and MB Outpatient pharmacy.

9/97 – 1/98
Interim Inpatient Assistant Pharmacy Service Manager - Oakland Medical Center

- Worked as Interim Inpatient Assistant Pharmacy Service Manager to manage 24-hour Inpatient Pharmacy service, Discharge Pharmacy, Pharmacy Ambulatory Care Service including Oncology and Coumadin Clinic. Prepared, participated and passed JACHO review for 1998.

11/94 - 12/95	***Outpatient Pharmacist-in-Charge - Walnut Creek Medical Center***
11/93 - 11/94	***Outpatient Pharmacist-in-Charge - Richmond Medical Center***
12/91 - 11/93	***Outpatient Staff Pharmacist - Richmond Medical Center***
8/91 - 8/92	***Outpatient and Inpatient Staff Pharmacist - Santa Teresa Medical Center***
8/90 - 8/91	***Outpatient and Inpatient Pharmacy Intern - Santa Teresa Medical Center***
4/89 - 12/90	***Outpatient Pharmacy Intern - Walnut Creek Medical Center***

Education

1991-1992 ***University of California, San Francisco***	***Pharmacy Residency Program in Geriatric***
1988-1991 ***University of the Pacific, School of Pharmacy***	***Doctor of Pharmacy***
1984-1988 ***University of Nevada, Reno***	***Pre-Pharmacy/Business Administration***

Professional Development/Training

2005 - 2006 *UCSF Pharmacy Leadership Program*	*Pharmacy Leadership Institute*
2004 *CAMP Program*	*Regional Pharmacy*
2000 *Microsoft Certified System Engineer (MCSE)*	*Self-Study*

Memberships in Professional Organizations/Community Groups

1988 - present	*Member of the California Pharmacists Association*
1988 - present	*Member of the Kappa Psi Pharmaceutical Professional Fraternity Alumni*

References

Lucian Cheng, Pharm D, Regional Pharmacy Service Manager – Regional Office (510)625-3836

Frank Choi, Pharm D, PRN Pharmacy Manager, Kaiser Permanente – Regional Office (510)816-2640

Calvin Wheeler, MD, Pharm D., Physician-in-Charge, Fremont Medical Center - GSAA (510)248-3111

A0734327

AMENDED AND RESTATED ARTICLES OF INCORPORATION
OF
KAISER FOUNDATION HOSPITALS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

NOV 05 2012

The undersigned certify that:

1. They are the President and the Assistant Secretary, respectively, of Kaiser Foundation Hospitals, a California nonprofit public benefit corporation.

2. The Articles of Incorporation of this corporation are amended and restated to read in their entirety as follows:

ONE: The name of this corporation is:

KAISER FOUNDATION HOSPITALS

TWO: This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for public and charitable purposes. This corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law effective January 1, 1980, not otherwise applicable to it under Parts 2 and 5 of Division 2 of Title 1 of the Corporations Code of the State of California.

THREE: This corporation is organized and shall at all times be operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), including specifically to improve the health of the communities it serves. Its activities include providing hospital, medical, and surgical care, including emergency services, extended care and home health care for members of the public without regard to the individual's ability to pay and in compliance with all applicable nondiscrimination requirements, including age, sex, race, religion, or national origin; engaging in activities designed to promote the general health of the communities it serves; educating and training medical students, physicians, and other health care professionals, and students in the healing arts; conducting, promoting and encouraging educational and scientific research in medicine and related sciences and medical and nursing education; and supporting the tax-exempt purposes of this corporation and its subsidiaries and of Kaiser Foundation Health Plan, Inc. and its subsidiaries. The corporation shall extend professional staff privileges to practitioners in the community.

FOUR: The corporation shall have no members.

FIVE: The corporation's Bylaws shall set forth the number of Directors.

SIX: The corporation's assets are irrevocably dedicated to charitable purposes. The corporation does not and shall not have the power to distribute gains, profits or dividends to its Directors or officers. Under no circumstances shall the corporation engage in any activities not permitted to be undertaken by an organization described in Code Section 501(c)(3). Moreover, the corporation shall not permit any part of its net earnings to inure to the benefit of any Director or officer of the corporation or to any other individual and shall not participate in, or intervene in (including the publishing or distributing of statements) any political campaign on behalf of (or in opposition to) any candidate for public office. The corporation may compensate Directors and officers for the reasonable value of goods and services that they furnish to the corporation.

Upon the corporation's liquidation or dissolution, the Board of Directors shall, after paying or adequately providing for the corporation's liabilities, distribute the corporation's assets to one or more organizations organized and operated exclusively for charitable purposes meeting the requirements of California Revenue and Taxation Code section 214 and exempt from tax under Code Section 501(c)(3) or any amendment or successor thereto. The corporation's assets may not be distributed so as to inure directly or indirectly to the benefit of any Director or officer of the corporation, or to any other individual, or to any corporation, trust or organization whose net earnings inure to the benefit of any individual.

3. The foregoing amendment and restatement of Articles of Incorporation was approved by the Board of Directors of the corporation by unanimous written consent in lieu of a meeting effective October 19, 2012.

4. The corporation has no members.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

DATE: November 5, 2012

Bernard Tyson, President

DATE: November 1, 2012

Victoria Zatkin, Assistant Secretary

I hereby certify that the foregoing transcript of 2 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office

NOV 06 2012

Date: _____

Debra Bowen

DEBRA BOWEN, Secretary of State

4AA

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 00238
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: Phoenix Assurance, LLC

Physical Address: 4750 Pleasant Hill Road

City: Memphis State: TN Zip Code: 38118

Telephone Number: 901 368 8940 Fax Number: 901 368 8990

Toll Free Number: _____

E-mail: rparks@pa3pl.com Website: www.pa3pl.com

Facility Manager: Rita Parks

Professional qualifications and experience of facility manager: BS Science with Chemistry minor, 18 years in this facility with varying owners

Types of licensed outlets or authorized persons firm will serve:

☑ Pharmacies ☐ Practitioners ☑ Hospitals ☑ Wholesalers
☑ Other: Clinics

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: Hikma Pharmaceuticals USA Inc.
Address: 4750 Pleasant Hill Road, Memphis, TN 38118

Name:
Address:

Name: N/A
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.

Rita Parks

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

Rita Parks

Print Name of Authorized Person

11/21/2019

Date

Board Use Only	Date Processed:_____	Amount: 500.00

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

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: Hulesy Britt %: 50

Name: Rita Parks %: 50

Name: _____ %: _____

Name: _____ %: _____

Partnership Name: Phoenix Assurance, LLC

Mailing Address: 4750 Pleasant Hill Road

City, State Zip Code: Memphis, TN 38118

Telephone Number: 901 368 8940 Fax Number: 901 368 8990

Contact Person: Rita Parks

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 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 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".

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

November 15, 2019

PHOENIX ASSURANCE, LLC
RITA PARKS
4750 PLEASANT HILL ROAD
MEMPHIS, TN 38118

Request Type: Certificate of Existence/Authorization
Request # 0338708

Issuance Date 11/15/2019
Copies Requested 1

Document Receipt

Receipt # 005108346 — Filing Fee $20.00
Payment-Credit Card - State Payment Center - CC # 3769579131 — $20.00

Regarding: Phoenix Assurance, LLC

Filing Type	Limited Liability Company - Domestic	Control #	990901
Formation/Qualification Date	10/19/2018	Date Formed	10/19/2018
Status	Active	Formation Locale	TENNESSEE
Duration Term	Perpetual	Inactive Date	
Business County	SHELBY COUNTY		

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

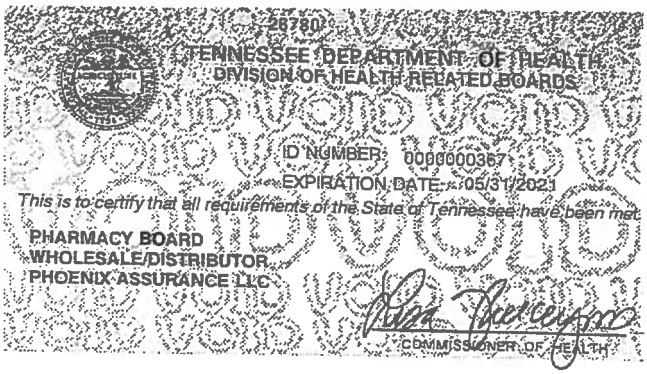
Phoenix Assurance, LLC

* is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;
* 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 Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed

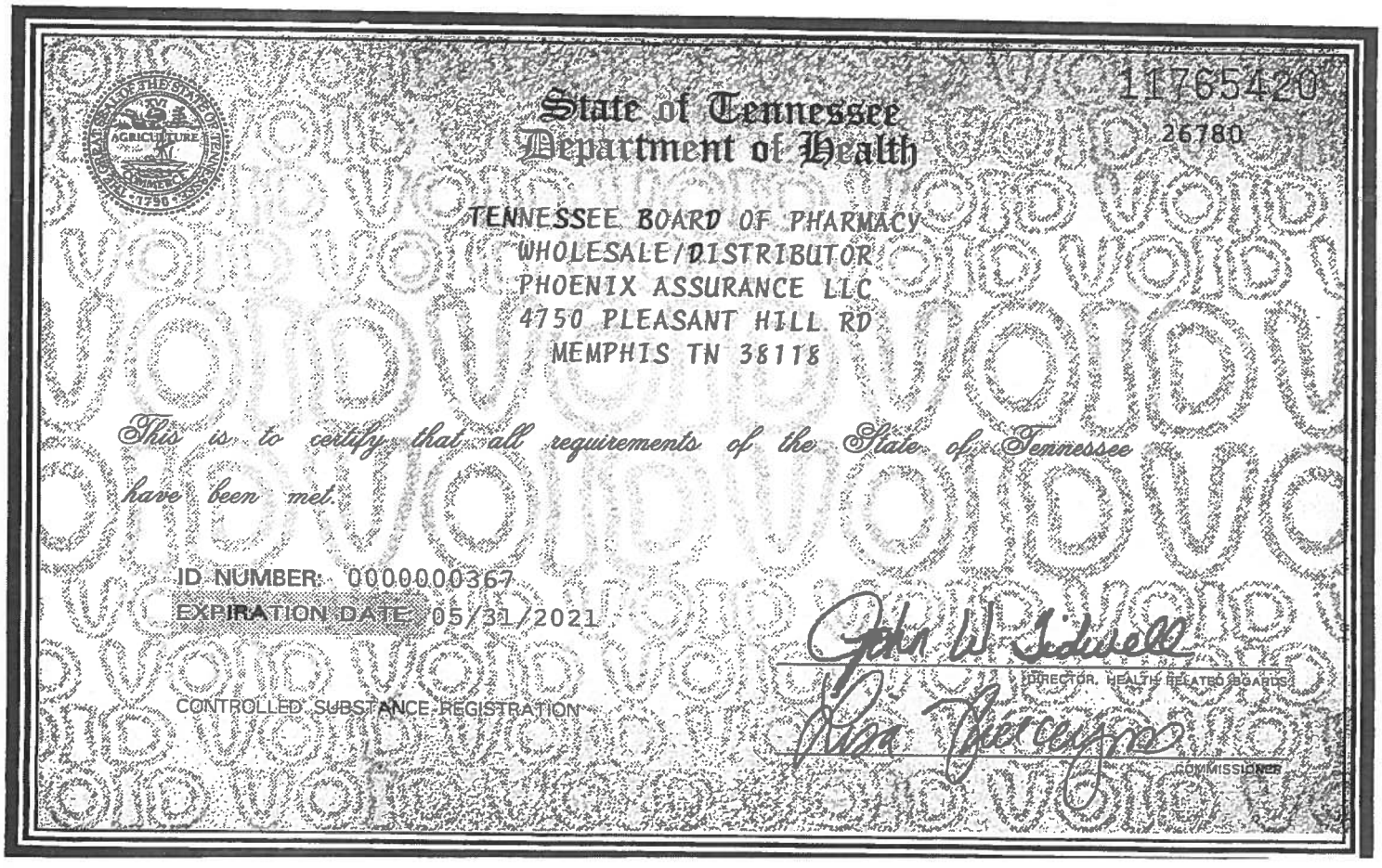
Tre Hargett
Secretary of State

Processed By Cert Web User

Verification #: 036342632



RITA PARKS
PHOENIX ASSURANCE LLC
4750 PLEASANT HILL RD
MEMPHIS TN 38118-7809



Nevada State Board Of Pharmacy

(Firm mailing address for window envelope)

THIS STUB IS YOUR RECEIPT

Date: 09/19/2018
Amount: $ 515.00
Permit #: WH00238

HIKMA PHARMACEUTICALS USA INC.
4750 PLEASANT HILL RD
MEMPHIS TN 38118

(ID Card)

NEVADA STATE BOARD OF PHARMACY

Wholesaler
Expires:10/31/2020
HIKMA PHARMACEUTICALS USA INC.
4750 PLEASANT HILL RD
MEMPHIS TN 38118

Permit #
WH00238
Active

IDENTIFICATION ONLY
DOES NOT MEET POSTING REQUIREMENTS

Trim ID Card to fit your wallet

NEVADA
STATE BOARD OF PHARMACY
Wholesaler

Permit Type: Wholesaler
Permit #: WH00238

Expires: 10/31/2020
STATUS: Active

THE UNDER-NOTED HAVING PAID STATUTORY FEE IS HEREBY LICENCED

HIKMA PHARMACEUTICALS USA INC.
4750 PLEASANT HILL RD
MEMPHIS TN 38118

NONTRANSFERABLE

POST THIS PERMIT PROMINENTLY IN A CONSPICUOUS PLACE

The National Association of Boards of Pharmacy®

hereby awards

Verified-Accredited Wholesale Distributors®

Accreditation

to

Phoenix Assurance, LLC

dba Phoenix Assurance

located at

4750 Pleasant Hill Rd, Memphis, TN 38118

This facility has met all the Verified-Accredited Wholesale Distributors (VAWD) criteria set in place by the National Association of Boards of Pharmacy. The current status of this facility's accreditation may also be verified by visiting the VAWD section of the NABP website, located at www.nabp.pharmacy.

Carmen A. Catizone, Executive Director/Secretary

October 15, 2018 - October 14, 2021

Period of Accreditation

National Association of Boards of Pharmacy | 1600 Feehanville Drive, Mount Prospect, IL 60056 | www.nabp.pharmacy

Facility Name

State (All)

Search Reset

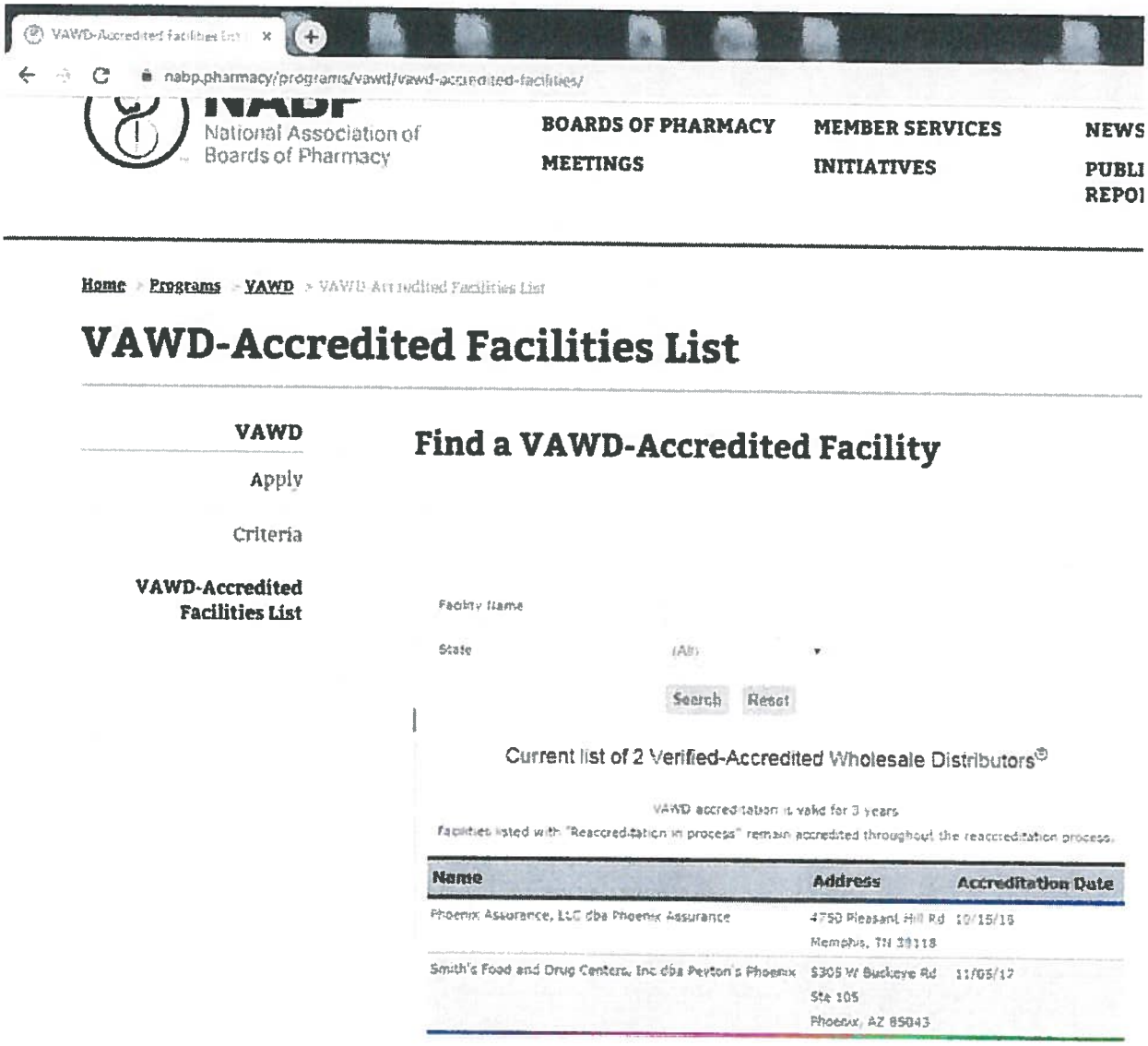
Current list of 1 Verified-Accredited Wholesale Distributors®

VAWD accreditation is valid for 3 years

Facilities listed with "Reaccreditation in process" remain accredited throughout the reaccreditation process.

Name	Address	Accreditation Date
Phoenix Assurance, LLC dba Phoenix Assurance	4750 Pleasant Hill Rd Memphis, TN 38118	10/15/18

Verified DZ



nabp.pharmacy/programs/vawd/vawd-accredited-facilities/

National Association of Boards of Pharmacy

BOARDS OF PHARMACY | MEMBER SERVICES | NEWS
MEETINGS | INITIATIVES | PUBLI REPOI

Home > Programs > VAWD > VAWD Accredited Facilities List

VAWD-Accredited Facilities List

VAWD
Apply
Criteria
VAWD-Accredited Facilities List

Find a VAWD-Accredited Facility

Facility Name
State (All)
Search Reset

Current list of 2 Verified-Accredited Wholesale Distributors®

VAWD accreditation is valid for 3 years
Facilities listed with "Reaccreditation in process" remain accredited throughout the reaccreditation process.

Name	Address	Accreditation Date
Phoenix Assurance, LLC dba Phoenix Assurance	4750 Pleasant Hill Rd Memphis, TN 38118	10/15/15
Smith's Food and Drug Centers, Inc dba Peyton's Phoenix	3305 W Buckeye Rd Ste 105 Phoenix, AZ 85043	11/05/17

The National Association of Boards of Pharmacy®
hereby awards

Verified-Accredited Wholesale Distributors®
Accreditation
to

Hikma Pharmaceuticals USA, Inc

located at

4750 Pleasant Hill Rd, Memphis, TN 38118

This facility has met all the Verified-Accredited Wholesale Distributors (VAWD) criteria set in place by the National Association of Boards of Pharmacy. The current status of this facility's accreditation may also be verified by visiting the VAWD section of the NABP website, located at www.nabp.pharmacy.

Carmen A. Catizone, Executive Director Secretary

October 15, 2018 - October 14, 2021
Period of Accreditation

National Association of Boards of Pharmacy | 1600 Feehanville Drive, Mount Prospect, IL 60056 | www.nabp.pharmacy

Phoenix Assurance, LLC

www.pa3pl.com

South Point
Warehouse/Distribution

4750 Pleasant Hill Road
Memphis, TN 38118
901-368-8941

Monday, December 16, 2019

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy
Suite 206
Reno, NV 89521

Re: Application for Out-of-State Wholesaler License – Change of Ownership / Name
From: Hikma Pharmaceuticals USA Inc. [License WH00238]
To: PHOENIX ASSURANCE, LLC

Dear Board,

I am providing this supplemental letter as clarification to one of the documents that was uploaded with our application for Phoenix Assurance, LLC. This facility was previously Hikma Pharmaceuticals USA Inc. (which was rebranded/formerly known as West-Ward Pharmaceutical Corp).

VAWD Certificate:
The NABP completed the 3-year reaccreditation of this facility September 2019 as well as the Annual Compliance Review in October 28, 2019. The name change to Phoenix Assurance was finalized last week (see attached online verification), but we have not yet received an updated VAWD Reaccreditation Certificate. Upon receipt of the updated VAWD Certificate – to Phoenix Assurance, LLC, we will provide a copy to the board.

Thanks,

Rita Parks
Vice President / Managing Partner
PHOENIX ASSURANCE, LLC
Phone: 901-368-8944
Email: rparks@pa3pl.com

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206
Reno, NV 89521
(775) 850-1440
Fax: (775) 850-1444

PHARMACEUTICAL WHOLESALER SURETY BOND

Bond No. 3475060

Application/License No. WH00238

PHOENIX ASSURANCE, LLC (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is 4750 PLEASANT HILL RD, MEMPHIS, Tennessee, 38118 (Address of Applicant/Principal), as PRINCIPAL, and SureTec Insurance Company (Surety Company), a corporation organized under the laws of the state of Texas (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is ____ CityWest Boulevard, Houston Texas 77042 United States (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 TWENTY-FIVE THOUSAND DOLLARS ($25,000.00), 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 Jan 13, 2020 (Effective Date).

WHEREAS, the provisions of Nevada Revised Statue (NRS) 639.515 and Nevada Administrative Code (NAC) 639.5937 require that the Applicant/Principal file or have on file with the Nevada State Board of Pharmacy (Board) a bond in the sum of $25,000.00 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.

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 14th day of January, 2020, 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.

To verify the bond please visit https://www.suretybond.org/validate/?code=eKRZUWAC3DAEJVVUZXXXF55g

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/30/2019

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 OUT OF STATE WHOLESALE LICENSE (BOARD OF PHARMACY

Nature of License

PHOENIX ASSURANCE, LLC, 4750 PLEASANT HILL ROAD, MEMPHIS, TN 38118

Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

PARKS	RITA	DENELL
Last Name	First Name	Middle Name

RITA DENELL POTTS, RITA POTTS PARKS

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

CR 632		CORINTH	MS 38834
Present Residence Address-Street or RFD		City	State/Zip
4750 PLEASANT HILL ROAD	Dates	MEMPHIS	TN 38118
Present Business Address		City	State/Zip
PHOENIX ASSURANCE, LLC VP / MANAGING PARTNER	Dates	05/01/2019 - PRESENT	
Occupation			Phone: Residence [redacted]
		CORINTH, ALCORN, MS	Business
Date of Birth		Place of Birth (City, County, State)	

56		FEMALE
Age	Social Security Number	Sex

BROWN	BROWN	OLIVE	130 lbs	MEDIUM	5' 9"
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. N/A

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

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

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage** 05/17/1984 (Date) CORINTH, ALCORN MS (City, County and State)

Spouse's full name (Maiden) MICHAEL SCOTT PARKS S.S. No

Date of Birt Place of Birth CORINTH, MS

Resident address CR 632 (Street) CORINTH (City) MS (State) 38834 (Zip)

Telephone: Resider Business (662) 665-2208

Spouse's employer LACOSTA Occupation PERSONNEL MANAGER

Address of employer WEST BONNER ROAD (Street) WAUCONDA (City) IL (State) 60084 (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
N/A				

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

Name	Street	City	State	Zip	Telephone
N/A					

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
HANNAH PARKS MITCHEI		GERMANTOWN, TN	CR 632, CORINTH, MS 38834

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 N/A

Address

Contact person

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	WILLIAM NELSON POTTS		CR 200, CORINTH, MS 38834	RETIRED
Mother	JUANELL LAMBERT POTTS		CR 200, CORINTH, MS 38834	RETIRED
Father-in-Law	N/A			
Mother-in-Law	N/A			

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
	SHANNON POTTS HARDWICK		PLANTERS GROVE, BRANDON, MS	PHARMACIST
Spouse	KELLY HARDWICK		LANTERS GROVE, BRANDON, MS	ATTORNEY
	N/A			
Spouse				
	N/A			
Spouse				
	N/A			
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	FARMINGTON ELEMENTARY	FARMINGTON, MS	1968-74	Yes ☒ No ☐
High School	ALCORN CENTRAL H.S.	CORINTH, MS	1974-80	Yes ☒ No ☐
College University	UNIVERSITY OF MISSISSIPPI	OXFORD, MS	1980-85	Yes ☒ No ☐
Other	N/A			Yes ☐ No ☐

Type of degree obtained, if any BACHELOR OF SCIENCE - BIOLOGY

College or university where obtained UNIVERSITY OF MISSISSIPPI

Applicant's initial

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☐ No ☒

Branch N/A Date of entry-active service N/A

Date of separation N/A Type of discharge N/A

Rating at separation N/A Serial number N/A

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 N/A State N/A Date registered N/A

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
N/A					

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes. furnish details on page 10.

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes ☐ No ☒

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒
If yes, when? N/A city, county and state N/A

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒
If yes when? N/A city, county and state N/A

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
N/A				

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
N/A				

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
N/A		

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
FEB 1993 - PRESENT	CR 632	CORINTH	MS

Applicant's initial ....

8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
MAY 2019	PHOENIX ASSURANCE, LLC: 4750 PLEASANT HILL RD, MEMPHIS, TN 38118	NOT APPLICABLE
Title	**Description of Duties**	**Name of Supervisor**
VP / MANAGING PARTNER	DIRECTOR OF QUALITY / ACTING QUALITY MANAGER	SELF

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
JUNE 2011 - MAY 2019	HIKMA PHARMACEUTICALS USA INC. (f/k/a WEST-WARD PHARMACEUTICALS CORP.) 4750 PLEASANT HILL RD, MEMPHIS, TN 38118	HIKMA CEASED OPERATIONS AT THIS LOCATION.
Title	**Description of Duties**	**Name of Supervisor**
SENIOR QUALITY MANAGER	MANAGEMENT OF QUALITY FUNCTIONS	ASUTOSH SHAH

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2004 - MAY 2011	BAXTER HEALTHCARE: 4750 PLEASANT HILL RD, MEMPHIS, TN 38118	BAXTER WAS PURCHASED BY WEST-WARD.
Title	**Description of Duties**	**Name of Supervisor**
QUALITY MANAGER	MANAGEMENT OF QUALITY FUNCTIONS	CHRIS GLADWELL

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2001 - 2004	MARIETTA CORPORATION	BETTER OPPORTUNITY
Title	**Description of Duties**	**Name of Supervisor**
DIRECTOR OF QUALITY	MANAGEMENT OF QUALITY ASSURANCE DEPARTMENT	LISA BRYSON

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2000 - 2001	ACT MANUFACTURING, INC.	BETTER OPPORTUNITY
Title	**Description of Duties**	**Name of Supervisor**
CORP. DIR. OF QUALITY	RESPONSIBLE FOR ESTABLISING UNIFORM CQI SYSTEM	MIKE SMITH

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1997 - 2000	CCL CUSTOM MFG., INC.: SOUTH THIRD ST., MEMPHIS, TN	HEWLETT - PACKARD CEASED OPERATIONS
Title	**Description of Duties**	**Name of Supervisor**
ASSOC. TECHNICAL DIRECTOR OF QA QUALITY ASSURANCE MANAGER	MANAGED QUALITY FUNCTIONS MANAGED LABS	TREY DAVIS

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1997	OHMEDA PHARMACEUTICAL	BETTER OPPORTUNITY
Title	**Description of Duties**	**Name of Supervisor**
QUALITY ASSURANCE SPECIALIST	FACILITY AUDITS TO INSURE COMPLIANCE W/ COMPANY POLICIES	WALL JASPER

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1987 - 1996	SCHERING -PLOUGH HEALTHCARE PRODUCTS	MFG DISCONTINUED AT SITE
Title	**Description of Duties**	**Name of Supervisor**
SENIOR QUALITY AUDITOR QUALITY AUDITOR II PRODUCT VERIF TECHNICIAN	SUPERVISED QUALITY AUDITORS, INSPECTORS &TECHNICIANS AUDITED FINISHED PRODUCTS TO COMPLY WITH AQLS QUALITATIVE & CHEMICAL TESTING OF PRODUCTS	GLENN JONES

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 TREY DAVIS	Home	GUM TREE CV, CORDOVA TN 3801[illegible]				25 YEARS
Employer BAXTER HEALTHCARE	Business	MEMPHIS, TN 38118				
Name CATHERINE DAVIS	Home	[illegible]LLAS POND CV, COLLIERVILLE, TN 38018				10 YEARS
Employer N/A	Business	N/A				
Name VIRGINIA S. JONES	Home	ALEXANDRIA DR, COLLIERVILLE, TN 38017				10 YEARS
Employer RETIRED	Business	N/A				
Name SAUNDRA CONKLAN	Home	POPPY HILLS DR, COLLIERVILLE, TN 38017				25 YEARS
Employer BAXTER HEALTHCARE	Business	MEMPHIS, TN 38118				
Name GLORIA HUGGINS	Home	[illegible]E. [illegible]TH STREET, CORINTH, MS 38834				40 YEARS
Employer RETIRED	Business	N/A				

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

Box Number or Type of Depository	Location	City and State	Authorized Users
NOT APPLICABLE			

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

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

Yes ☐ No ☒
If yes, state type, where and years held

NOT APPLICABLE

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

PHOENIX ASSURANCE, LLC, 4750 PLEASANT HILL RD, MEMPHIS, TN 38118. PARTNERS: MYSELF AND RITA PARKS. RITA PARKS, 150 CR 632, CORINTH, MS 38834. LLC INCORPORATED IN TENNESSEE ON 10/19/2019. BUSINESS LICENSES OBTAINED BY MEMPHIS/SHELBY COUNTY, TN. WHOLESALER/ DISTRIBUTOR LICENSE OBTAINED FROM THE TENNESSEE BOARD OF PHARMACY.

Applicant's initial

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

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

If yes to the above, state where, when and for what reason:
NOT APPLICABLE

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

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

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

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

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

SISTER - SHANNON POTTS HARDWICK, PHARMACIST

Date of photograph 12/20/19

Applicant's initial

STATE OF TENNESSEE
ss.
COUNTY OF SHELBY

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

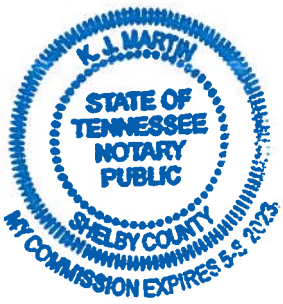
I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and their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

Original Signature of Applicant

Subscribed and Sworn to before me this 30TH day of DECEMBER, 2019

KIMBERLY J MARTIN

Notary Public



(seal)

Applicant's initial

ADDITIONAL INFORMATION

N/A
BD 12/30/19

Applicant's initial

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/30/2019

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 OUT OF STATE WHOLESALE LICENSE (BOARD OF PHARMACY)
Nature of License

PHOENIX ASSURANCE, LLC, 4750 PLEASANT HILL ROAD, MEMPHIS, TN 38118
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

BRITT	HULESY	N/A
Last Name	First Name	Middle Name

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

272 S. MAIN STREET, APT. 417	MEMPHIS	TN 38103
Present Residence Address-Street or RFD	City	State/Zip

4750 PLEASANT HILL RD, MEMPHIS, TN 38118 Dates	JUNE 2011 - PRESENT	
Present Business Address	City	State/Zip

PHOENIX ASSURANCE, LLC
PRESIDENT / MANAGING PARTNER Dates MAY 1, 2019 - PRESENT
Occupation

Phone:
Residence [redacted]
Business 901-368-8942

	MEMPHIS, SHELBY COUNTY, TN
Date of Birth	Place of Birth (City, County, State)

52		MALE
Age	Social Security Number	Sex

BROWN	BALD	MEDIUM-DARK	191	SLENDER/FIT/MUSCULAR	6' 1"
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 N/A

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

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

2. MARITAL INFORMATION:

Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage** NOT APPLICABLE

Spouse's full name (Maiden) N/A (Date) City, County and State S.S. No N/A

Date of Birth N/A Place of Birth N/A

Resident address N/A (Street) N/A (City) N/A (State) N/A (Zip)

Telephone: Residence N/A Business N/A

Spouse's employer N/A Occupation N/A

Address of employer N/A (Street) N/A (City) N/A (State) N/A (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
KAROL MACLIN	04/16/2003	MEMPHIS, TN	DIVORCE	MEMPHIS / SHELBY / TN

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

Name	Street	City	State	Zip	Telephone
KAROL MACLIN	LEETS HARBOR DRIVE	MEMPHIS	TN	38103	

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
KRISTIAN MYERS	[redacted]	MEMPHIS, TN	LEETS HARBOR DR. MEMPHIS, TN 38103
KWINCI BRITT		MEMPHIS, TN	LEETS HARBOR DR. MEMPHIS, TN 38103

B. Child Support Information:

Please mark the appropriate response:

per Tami 01/29/2020 DZ

☒ 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 N/A

Address N/A

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	DOC BRITT	UNKNOWN	UNKNOWN	RETIRED
Mother	BARBARA HUNTER		VANDALE MEMPHIS, TN	DEPT. OF CHILDREN'S SERVICES
Father-in-Law	NOT APPLICABLE			
Mother-in-Law	NOT APPLICABLE			

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

	Name (Maiden)	Birth Date	Address	Occupation
Spouse	STACY HUBSON		RUBY CREEK CV, MEMPHIS, TN 38109	REALTOR/BROKER
	NOT APPLICABLE			
Spouse	NOT APPLICABLE			
Spouse	NOT APPLICABLE			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	HAWKINS MILL	MEMPHIS, TN	1977	Yes ☒ No ☐
High School	TREZEVANT HIGHT SCHOOL	MEMPHIS, TN	1985	Yes No
College University	UNIVERSITY OF MEMPHIS	MEMPHIS, TN	1998	Yes ☐ No ⊘
Other	NOT APPLICABLE			Yes ☐ No ☐

Type of degree obtained, if any N/A

College or university where obtained N/A

Applicant's initial

5 MILITARY INFORMATION:

A. Have you ever served in any armed forces? Yes ☒ No ☐

Branch U.S. MARINE CORP Date of entry-active service 1987

Date of separation 2000 Type of discharge HONORABLE

Rating at separation B-4 Serial number UNKNOWN

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 SHELBY State TENNESSEE Date registered 1985

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
N/A					
N/A					
N/A					

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes. furnish details on page 10.

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes ☐ No ☒

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒
If yes, when? city, county and state

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒
If yes when? city, county and state

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes ☐ No ☒
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date
N/A				
N/A				
N/A				

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
N/A				
N/A				
N/A				

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
N/A		
N/A		
N/A		
N/A		

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
SEPT. 2019 - PRESENT	TENNESSEE STREET	MEMPHIS	TN 38103
FEB. 2015 - SEP. 2019	S. MAIN STREET, APT. 417	MEMPHIS	TN 38103
JAN. 2007 - FEB. 2015	SHOEMAKER COURT, APT. 108	MEMPHIS	TN 38103
MAR. 2003 - JAN. 2007	S. FRONT #217	MEMPHIS	TN 38103
MAY 1999 - MAR. 2003	FOUNTAIN RIVER	MEMPHIS	TN 38120
2000 - 2003	NO RECALL	MEMPHIS	TN
1987 - 2000 - U.S. MARINE CORP			

Applicant's initial .....

8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
MAY, 2019	PHOENIX ASSURANCE, LLC: 4750 PLEASANT HILL RD., MEMPHIS, TN 38118	NOT APPLICABLE
Title	**Description of Duties**	**Name of Supervisor**
PRESIDENT/MANAGING PARTNER	FACILITY MANAGER/OPERATIONS	SELF

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1991 - 2018	HIKMA PHARMACEUTICALS USA INC. 4750 PLEASANT HILL RD., MEMPHIS, TN 38118	HIKMA CEASED OPERATIONS AT THIS LOCATION.
Title	**Description of Duties** f/k/a West-Ward Pharmaceutical Corp. f/k/a Baxter Healthcare	**Name of Supervisor**
ASSOC. DIRECTOR, DISTIRUBTION	FACILITY MANAGER/OPERATIONS	OMAR

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1985 - 2001	U.S. MARINE CORP	TOUR ENDED
Title	**Description of Duties**	**Name of Supervisor**
PETROLEUM ENGINEER / MARKSMANSHIP INSTRUCTOR		

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
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 RICK FARWELL	Home	MEMPHIS, TN		34 YEARS
Employer SELF EMPLOYED	Business	PYRAMID WINE & SPIRITS, MEMPHIS, TN		
Name KAREN WALKER	Home	MEMPHIS, TN		5 YEARS
Employer AEROTEK	Business	AEROTEK, MEMPHIS, TN		
Name AARON HALL	Home	MEMPHIS, TN		10 YEARS
Employer VERIZON	Business	VERIZON, MEMPHIS, TN		
Name JOYE MOSBY	Home	MEMPHIS, TN		15 YEARS
Employer MLGW	Business	MLGW, MEMPHIS, TN		
Name TIERINY HENDRICKS	Home	MEMPHIS, TN		14 YEARS
Employer CENTER FOR EMPLOYMENT OPPORTUNITIES	Business	MEMPHIS, TN		

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

Box Number or Type of Depository	Location	City and State	Authorized Users
PO BOX 3344	PEABODY PLACE	MEMPHIS, TN	HULESY BRITT

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

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

Yes ☒ No ☐
If yes, state type, where and years held

CALIFORNIA - EXE 1865 DESIGNATED REPRESENTATIVE

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

PHOENIX ASSURANCE, LLC, 4750 PLEASANT HILL RD, MEMPHIS, TN 38118. PARTNERS: MYSELF AND RITA PARKS. RITA PARKS, 150 CR 632, CORINTH, MS 38834. LLC INCORPORATED IN TENNESSEE ON 10/19/2019. BUSINESS LICENSES OBTAINED BY MEMPHIS/SHELBY COUNTY, TN. WHOLESALER/DISTRIBUTOR LICENSE OBTAINED FROM THE TENNESSEE BOARD OF PHARMACY.

Applicant's initial

13. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

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

If yes to the above, state where, when and for what reason:
NOT APPLICALBLE

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

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

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

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

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

Date of photograph 12/27/2019

Applicant's initial

STATE OF TENNESSEE
ss.
COUNTY OF SHELBY

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

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

Original Signature of Applicant

Subscribed and Sworn to before me this 30TH day of DECEMBER, 2019

KIMBERLY J MARTIN

Notary Public

K. J. MARTIN
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY
MY COMMISSION EXPIRES 5-9-2023

(seal)

Applicant's initial

ADDITIONAL INFORMATION

N/A
BD 12/30/19

Applicant's initial

4BB

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: Kaiser Foundation Hospitals

Physical Address: 300 Pullman Street, Admin Building

City: Livermore, CA State: CA Zip Code: 94551 Telephone

Number: 925-294-7409 Fax Number: 925-960-7527

Toll Free Number: N/A

E-mail: derrick.a.lew@kp.org Website: healthy.kaiserpermanente.org

Facility Manager: Derrick Lew

Professional qualifications and experience of facility manager: Over 10 years of experience in wholesale distribution and facility management. 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 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: Hikma Pharmaceutical
Address: 401 Industrial Way West, Eatontown, NJ 207724

Name: Glaxo Smithkline
Address: One Franklin Plaza, Philadelphia, PA 19102

Name: Eli Lilly & Co
Address: 916 Mutal Savings Building, Pasadena, CA 91101

Name: Sandoz, Inc.
Address: 2555 West Midway Blvd., Broomfield, CA 80020

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

Terry Smith
Print Name of Authorized Person

11/12/2019
Date

Board Use Only	Date Processed:_____	Amount: _____

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: DE

Parent Company if any: N/A

Mailing Address: 300 Pullman Street, Admin Building

City: Livermore State: CA Zip: 94621

Telephone: 925-294-7409 Fax: 925-960-7527

Contact Person: Derrick Lew

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 - Registered as a non-profit public benefit corporation. No owners/members.
Name Business Address

b) N/A
Name Business Address

c) N/A
Name Business Address

d) N/A
Name Business Address

2) Provide the number of shares issued by the corporation. 0

3) What was the price paid per share? 0

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 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.

Kaiser Foundation Hospitals, Inc.
List of Officers

Corporate Officers	Office Address
Troy Smith, Executive Director, National Warehousing and Logistics	E. Walnut Street Pasadena, CA 91188
Joseph Montero, Assistant Director, Pharmacy Materials Services	Dalen Street Downey, CA 90242

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:

KAISER FOUNDATION HOSPITALS

FILE NUMBER:	C0224971
FORMATION DATE:	02/20/1948
TYPE:	DOMESTIC NONPROFIT 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 December 31, 2019.

ALEX PADILLA
Secretary of State

DLS

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Board of Pharmacy

ORIGINAL CERTIFICATE

Wholesale Drug Permit

LICENSE NO. WLS 7439

ISSUE DATE JULY 12, 2019

KAISER FOUNDATION HOSPITALS

300 PULLMAN ST ADMIN BLDG
LIVERMORE CA 94551

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

CORPORATION
DERRICK ANTHONY LEW — EXEMPTEE IN CHARGE

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

PLACE RENEWAL LICENSE HERE

VALID UNTIL JULY 01, 2020

RECEIPT NUMBER 00640717

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

In accordance with section 4060 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 NONTRANSFERABLE and must be renewed annually on or before the indicated date. Contact the California State Board of Pharmacy within 30 days when there is a change of ownership, location, corporate officer, shareholder (more than 10 percent share change), designated representative-in-charge, manager or vice president of operations. If you are planning to change location or designated representative-in-charge, the approval must be in advance of the change.

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

2/19
2/19

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

OPHWS1 02/29/08 WLS

Derrick Lew, Pharm.D., MBA

300 Pullman St. Bldg A
Livermore, CA 94551
(925) 294-7409
derrick.a.lew@kp.org

Education

University of the Pacific-Thomas J. Long School of Pharmacy
And Eberhardt School of Business
Joint Degree Pharm.D./ MBA Program 2006-2009
Stockton, CA

Work Related Experience

Kaiser Permanente Foundation Hospitals March 2009-Present
Pharmacy Repack Manager
300 Pullman St. Unit A
Livermore, CA 94551
Manager: Perry Lau (510) 434-5858

Responsibilities:

- Maintain pharmaceutical manufacturing standards according to Title 21, cGMP, FDA, DEA, and CA Department of Public Health. Ensure products are the highest quality and in adequate supply at the Distribution Center.
- Audits: FDA Jun 2011, Oct 2016; DEA Aug 2012, Apr 2015
- Expanded number of SKUs for various product line: unit of use, unit dose, liquid unit dose, and reverse bulk items.
- Capital Equipment: Successfully upgraded and installed equipment Line #1; increased throughput from 30-50 bottles/minute to 100-120 bottles/minute. Maintain current equipment (4 production lines, 2 unit dose workstations, 1 liquid unit dose workstation and 2 reverse bulk workstations) with 10 year capital replenishment plan in place.
- Overall Equipment Effectiveness: Created process to gather and document OEE data as a metric of production efficiency and how to increase production time.
- Unit Base Team: Worked with staff in a Labor Management Partnership to create a process for the UBT team to disseminate information to the entire staff. The UBT team has been assigned projects to increase workflow efficiencies.

CVS/Pharmacy-Pharmacist Aug 2009-2010
515 N State Highway 49
Jackson, CA 95642
Manager: Kathi Erosa (209) 223-2471

Responsibilities:

- Staff pharmacist for a store with script volume of 1400 per week. Review and verify prescription for accuracy and safety. Prescription review includes ensuring the safety of the patients with drug utilization review as complying with State Board of Pharmacy regulations.

- Answering customer questions and concerns regarding over-the-counter products.
- Lead the pharmacy staff to efficient workflow processes while providing high level of customer service.

Raley's-Pharmacist Aug 2009 – 2010
2323 West Hammer Lane
Stockton, CA 95209
Manager: Harvey Lee (209) 955-1510

Responsibilities:

- Relief staff pharmacist for a store with script volume of 1000 per week. Review and verify prescription for accuracy and safety. Prescription review includes ensuring the safety of the patients with drug utilization review as complying with State Board of Pharmacy regulations.
- Answering customer questions and concerns regarding over-the-counter products.

Licenses, Certificates, Competencies, and Proficiencies

Pharmacist License #62802 Exp: Oct 31, 2018

Certified Professional
Center for Professional Innovation and Education (CfPIE) – certificate program to demonstrate technical training for Pharmaceutical, Biotech, and Medical Device professionals. Course topics and completion dates below:

Drug Development Process from Concept to Market	Jan 2018
Stability Programs for Determining Product Shelf Life	Oct 2017
Best Practices for an Effective Cleaning Validation Program	Sept 2017
Process Validation for Drugs and Biologics	Jul 2017
Pharmaceutical Root Cause Analysis of Failures and Deviations-Developing an Effective CAPA strategy	June 2016

Lean Six Sigma Green Belt Certified Dec 2016
Cold chain improvement for Pharmacy Distribution Center. Increased compliance and regulatory oversight to cold chain management. Developed process controls such as system validation, MKT excursion analysis, and BMS alerts/responses. Developed contingency plan and response to excursions. Cost avoidance of $150 million for regulatory compliance.

IQPC Pharmaceutical Traceability Forum May 2016
International Quality & Productivity Center hosted a traceability forum for industry to discuss the Drug Supply Chain Security Act. Topics include GS1 standards, pedigree, aggregation, and solutions for manufacturers and distributors.

FDA May 2012, Apr 2016
FDA hosted conference to ensure industry compliance, inspection readiness and response to warning letters. It also focused on firm's robustness of its own quality systems,

contractor oversight, data integrity/electronic data systems, and corrective action preventative action (CAPA) processes.

cGMP by the Sea Conference Jul 2013, Aug 2014, Aug 2017
Pharma Conference hosts annual conference with current FDA officers covering topics such as supply chain security, registering products appropriately, FDA audit protocol, handling 483 citations, quality management, inspection practices, and adequate training for staff. Current FDA auditors share findings from inspections with pharmaceutical manufacturers.

DEA Annual Conference Apr 2011, Feb/May 2015, May 2016
DEA annual conference with DEA inspectors covering topics such as security, reporting loss-DEA Form 106, ARCOS reporting, CSOS, inspection practices and future status of hydrocodone products and the requirements for Manufacturers and Distributors.

Kaiser Permanente Management Excellence Program Jul 2010
Kaiser Permanente management training program for new managers. Training covered topics such as emotional intelligence, working in Labor Management Partnership environment, and creating effective managers.

Extracurricular Activities

SALUD Outreach
Health Fair Stockton, CA Jan 2013
A health fair focused on the Hispanic community. Free health screenings were provided to the community to identify at risk patients. Precept pharmacy interns in health screenings: diabetes, hypertension, and hyperlipidemia.

Living Hope Health Fair
Health Fair Stockton, CA June 2012, 2013
A collaborative community every with the Bread of Life program to provide free health screenings and general health education to the local community in need. Precept pharmacy interns in health screenings: diabetes, hypertension, hyperlipidemia, MTM, and bone density.

Multicultural Health Day
Health Fair Stockton, CA Oct 2010
An outreach health fair aimed to provide free health screenings and cultural awareness to the local community. Precept pharmacy students with health screenings and over-the-counter education.

A0734327

AMENDED AND RESTATED ARTICLES OF INCORPORATION

OF

KAISER FOUNDATION HOSPITALS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

NOV 05 2012

The undersigned certify that:

1. They are the President and the Assistant Secretary, respectively, of Kaiser Foundation Hospitals, a California nonprofit public benefit corporation.

2. The Articles of Incorporation of this corporation are amended and restated to read in their entirety as follows:

ONE: The name of this corporation is:

KAISER FOUNDATION HOSPITALS

TWO: This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for public and charitable purposes. This corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law effective January 1, 1980, not otherwise applicable to it under Parts 2 and 5 of Division 2 of Title 1 of the Corporations Code of the State of California.

THREE: This corporation is organized and shall at all times be operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), including specifically to improve the health of the communities it serves. its activities include providing hospital, medical, and surgical care, including emergency services, extended care and home health care for members of the public without regard to the individual's ability to pay and in compliance with all applicable nondiscrimination requirements, including age, sex, race, religion, or national origin; engaging in activities designed to promote the general health of the communities it serves; educating and training medical students, physicians, and other health care professionals, and students in the healing arts; conducting, promoting and encouraging educational and scientific research in medicine and related sciences and medical and nursing education; and supporting the tax-exempt purposes of this corporation and its subsidiaries and of Kaiser Foundation Health Plan, Inc. and its subsidiaries. The corporation shall extend professional staff privileges to practitioners in the community.

FOUR: The corporation shall have no members.

FIVE: The corporation's Bylaws shall set forth the number of Directors.

SIX: The corporation's assets are irrevocably dedicated to charitable purposes. The corporation does not and shall not have the power to distribute gains, profits or dividends to its Directors or officers. Under no circumstances shall the corporation engage in any activities not permitted to be undertaken by an organization described in Code Section 501(c)(3). Moreover, the corporation shall not permit any part of its net earnings to inure to the benefit of any Director or officer of the corporation or to any other individual and shall not participate in, or intervene in (including the publishing or distributing of statements) any political campaign on behalf of (or in opposition to) any candidate for public office. The corporation may compensate Directors and officers for the reasonable value of goods and services that they furnish to the corporation.

Upon the corporation's liquidation or dissolution, the Board of Directors shall, after paying or adequately providing for the corporation's liabilities, distribute the corporation's assets to one or more organizations organized and operated exclusively for charitable purposes meeting the requirements of California Revenue and Taxation Code section 214 and exempt from tax under Code Section 501(c)(3) or any amendment or successor thereto. The corporation's assets may not be distributed so as to inure directly or indirectly to the benefit of any Director or officer of the corporation, or to any other individual, or to any corporation, trust or organization whose net earnings inure to the benefit of any individual.

3. The foregoing amendment and restatement of Articles of Incorporation was approved by the Board of Directors of the corporation by unanimous written consent in lieu of a meeting effective October 19, 2012.

4. The corporation has no members.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

DATE: November 5, 2012

Bernard Tyson, President

DATE: November 1, 2012

Victoria Zatkin, Assistant Secretary

I hereby certify that the foregoing transcript of 2 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

NOV 06 2012

Date

Debra Bowen

DEBRA BOWEN, Secretary of State

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. 070209552

Application/License No. _____

KAISER FOUNDATION HOSPITALS (Applicant/Principal), doing or intending to do business as a pharmaceutical wholesaler, whose address for purposes of service is 300 Pullman St., Admin Building Livermore, CA 94551 (Address of Applicant/Principal), as PRINCIPAL, and LIBERTY MUTUAL INSURANCE COMPANY (Surety Company), a corporation organized under the laws of the state of MA (State of Incorporation) and authorized to transact a general surety business in the State of Nevada, whose address for purposes of service is 175 Berkeley Street Boston, MA 02116 (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 10/11/2019 (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 11th day of October, 20 19.

APPLICANT/PRINCIPAL
KAISER FOUNDATION HOSPITALS

Authorized Representative

SURETY COMPANY
LIBERTY MUTUAL INSURANCE COMPANY

Surety Company's Representative

Edward C. Spector, Attorney-in-fact
print name

SIGNED and SEALED in the presence of:

Witness

Witness

SIGNED and SEALED in the presence of:

Witness B. Aleman

Witness April Martinez

Countersigned by:

Nevada Resident Agent
Marina Betsy Tapia
Non-Resident Producer
License No.: 884868

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

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 Los Angeles

On OCT 1 1 2019 before me, Tracy Aston, Notary Public, personally appeared Edward C. Spector who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that he/~~she~~/~~they~~ executed the same in his/~~her~~/~~their~~ authorized capacity(~~ies~~), and that by his/~~her~~/~~their~~ signature(~~s~~) on the instrument the person(~~s~~), or the entity upon behalf of which the person(~~s~~) acted, executed the instrument.

TRACY ASTON
Notary Public - California
Los Angeles County
Commission # 2285552
My Comm. Expires May 15, 2023

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

Liberty Mutual. SURETY

This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

Certificate No: 8198054-024029

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That The Ohio Casualty Insurance Company is a corporation duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, B. Aleman, Tracy Aston, Thomas Branigan, Lisa K. Crail, Ashraf Elmasry, Samantha Fazzini, Donna Garcia, Simone Gerhard, April Martinez, Rosa E. Rivas, Paul Rodriguez, Edward C. Spector, Marina Tapia, Nathan Varnold, KD Wapato

all of the city of Los Angeles state of California each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 28th day of November, 2018.

Liberty Mutual Insurance Company
The Ohio Casualty Insurance Company
West American Insurance Company

By: _____
David M. Carey, Assistant Secretary

State of PENNSYLVANIA
County of MONTGOMERY ss

On this 28th day of November, 2018 before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute 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 have hereunto subscribed my name and affixed my notarial seal at King of Prussia, Pennsylvania, on the day and year first above written.

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Upper Merion Twp., Montgomery County
My Commission Expires March 28, 2021
Member, Pennsylvania Association of Notaries

By: _____
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS: Section 12. Power of Attorney.
Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts: Section 5. Surety Bonds and Undertakings.
Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Renee C. Llewellyn, the undersigned, Assistant Secretary, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this ____ day of OCT 11 2019

By: _____
Renee C. Llewellyn, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

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 Alameda)

On October 23, 2019 before me, Colleen Dahle-Hong, Notary Public,
Date *Here Insert Name and Title of the Officer*

personally appeared Robert Venema
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

COLLEEN DAHLE-HONG
Commission No. 2207061
NOTARY PUBLIC-CALIFORNIA
ALAMEDA COUNTY
My Comm Expires AUGUST 22, 2021

Place Notary Seal Above

OPTIONAL

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document
Title or Type of Document: Rx Wholesale Surety Bond
Document Date: _____ Number of Pages: _____
Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: Robert Venema	Signer's Name:
☐ Corporate Officer — Title(s):	☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☑ General
☐ Individual ☐ Attorney in Fact	☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian or Conservator	☐ Trustee ☑ Guardian or Conservator
☐ Other:	☐ Other:
Signer Is Representing: KFH	Signer Is Representing:

Kaiser Foundation Hospitals

List of Employees Who Handle Drugs

Kaiser Foundation Hospitals ("KFH") is a virtual distributor. The facility located in Livermore, CA does not house, handle or distribute any drugs. All warehousing and distribution is performed by a licensed Third Party Logistics provider, United Parcel Service (UPS) in several locations within the United States.

Therefore, there are no KFH employees who handle any drugs on a daily basis.

4CC

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: THE ER AT McCARRAN NW

Physical Address: 10290 NORTH McCARRAN BLVD

City: RENO State: NV Zip Code: 89503 Telephone: 775-343-7520

Fax: 775-343-7519 Toll Free Number: _____

E-mail: KEITH.MARSHALL@UHSINC.COM

Website: _____

Managing Pharmacist: KEITH MARSHALL License Number: 11473 ✓

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: EMERGENCY ROOM	☐	☑ Sterile Compounding
		☐	☑ Non Sterile Compounding
	All boxes must be checked	☐	☑ Mail Service Sterile Compounding
	For the application to be complete	☑	☐ Other Services: PYXIS

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.

Keith Marshall

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

KEITH MARSHALL

Print Name of Authorized Person

2/10/2020

Date

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

APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: SPARKS FAMILY HOSPITAL, INC.

Business Name: NORTHERN NEVADA MEDICAL CENTER

Current Business Address: 2375 EAST PRATER WAY

City: SPARKS State: NV Zip Code: 89434

Telephone: 775-331-7000 Fax: 775-356-4932

List any physician shareholders and percentage of ownership.

Name:_____ %:_____

Name:_____ %:_____

Name:_____ %:_____

Name:_____ %:_____

Hours of Operation for the pharmacy:

Monday thru Friday_____am _____pm Saturday _____am _____pm

Sunday _____am _____pm 24 Hours ✓

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

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

I, KEITH MARSHALL
Responsible Person of THE ER AT McCARRAN NW
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.

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

KEITH MARSHALL
Print Name of Authorized Person

2/10/2020
Date

Managing Pharmacist

Pharmacist Name: KEITH MARSHALL License #: 11473

Pharmacy Name: THE ER AT McCARRAN NW

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: _____ Date: _____ Case #: _____

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

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

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

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

Keith Marshall
Signature

2/10/2020
Date

ENTITY INFORMATION

ENTITY INFORMATION

Entity Name:

SPARKS FAMILY HOSPITAL, INC.

Entity Number:

C1886-1979

Entity Type:

Domestic Corporation (78)

Entity Status:

Active

Formation Date:

04/06/1979

NV Business ID:

NV19791003372

Termination Date:

Perpetual

Annual Report Due Date:

4/30/2020

REGISTERED AGENT INFORMATION

Name of Individual or Legal Entity:

CORPORATION SERVICE COMPANY

Status:

Active

CRA Agent Entity Type:

Registered Agent Type:

Commercial Registered Agent

NV Business ID:

NV20101844335

Office or Position:

Jurisdiction:

DELAWARE

Street Address:

112 NORTH CURRY STREET, Carson City, NV, 89703, USA

Email Address:

SOP@CSCGLOBAL.COM

Mailing Address:

Individual with Authority to Act:

GEORGE MASSIH

Contact Phone Number:

Fictitious Website or Domain Name:

PRINCIPAL OFFICE ADDRESS

Address:

Mailing Address:

OFFICER INFORMATION

☐ **VIEW HISTORICAL DATA**

Title	Name	Address	Last Updated	Status

Title	Name	Address	Last Updated	Status
President	MARVIN PEMBER	: S GULPH RD, KING OF PRUSSIA, PA, 19406, USA	04/10/2019	Active
Secretary	MATTHEW D KLEIN	. GULPH ROAD, KING OF PRUSSIA, PA, 19406, USA	04/10/2019	Active
Treasurer	CHERYL K RAMAGANO	S GULPH RD, KING OF PRUSSIA, PA, 19406, USA	04/10/2019	Active
Director	STEVE FILTON	S GULPH RD, KING OF PRUSSIA, PA, 19406, USA	04/10/2019	Active

Page 1 of 1, records 1 to 4 of 4

CURRENT SHARES

Class/Series	Type	Share Number	Value

No records to view.

Number of No Par Value Shares:

2500

Total Authorized Capital:

2,500

Filing History Name History Mergers/Conversions

Return to Search Return to Results

411

EFFECTIVE
01/01/2020
EXPIRES
12/31/2020

State of Nevada
Department of Health and Human Services
Division of Public and Behavioral Health

License Number
653-HOS-29

This Is To Certify That

NORTHERN NEVADA MEDICAL CENTER

2375 E PRATER WAY
SPARKS, NV 89434

Is hereby licensed as a(n)

HOSPITAL

as provided for in Chapters 439 and 449 of the Nevada Revised Statutes and the Nevada Administrative Code and the standards, rules and regulations adopted by the Board of Health.

This facility is licensed to provide the following:

Facility Type : HOSPITAL

Endorsement : PRIMARY STROKE

Bed Information : Medical/Surgical Beds - 76,Medical/Surgical ICU Beds - 12,Rehabilitation Beds - 8,Geriatric Psychiatric Beds - 28

ALAN OLIVE / Administrator

UNIVERSAL HEALTH SERVICES INC/SPARKS FAMILY HOSPITAL INC

Lisa Sherych / Administrator