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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: AZBDBR, LLC dba AvasaRx Pharmacy

Physical Address: 816 N. 6th Ave.

Mailing Address: 816 N. 6th Ave.

City: Phoenix State: AZ Zip Code: 85003

Telephone: 480-900-7450 Fax: 833 437-2301

Toll Free Number: 844-482-2005 (Required per NAC 639.708)

E-mail: info@avasarx.com Website: AVASARX.COM

Managing Pharmacist: Ronak Modi License Number: S023110

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

- ☐ ☒ Retail
☐ ☒ Hospital (# beds _____)
☐ ☒ Internet
☐ ☒ Nuclear
☐ ☒ Ambulatory Surgery Center
☐ ☒ Community
☒ ☐ Other: Independent

All boxes must be checked

For the application to be complete

Yes/No

- ☐ ☒ Off-site Cognitive Services
☐ ☒ Parenteral **
☒ ☐ Parenteral (outpatient)
☐ ☒ Outpatient/Discharge
☒ ☐ Mail Service
☐ ☒ Long Term Care
☐ ☒ Sterile Compounding **
☐ ☒ Non Sterile Compounding
☐ ☒ Mail Service Sterile Compounding **
☒ ☐ Other Services: Home Infusion

****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

CHAITANYA GADDE

Print Name of Authorized Person

Date

11/1/2018

Page 2

Board Use Only

Date Processed: _____

Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIPGeneral _____ Limited LPartnership Name: AZBDBR, LLCMailing Address: 816 N. 6th Ave.City: Phoenix State: AZ Zip Code: 85003Telephone Number: 480-900-7450 Fax Number: 833-437-2301Contact Person: Ronak Modi

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

<u>Name</u>	<u>G or L</u>	<u>Percentage</u>
<u>Arizona Hemophilia Association</u>	<u>L</u>	<u>51%</u>
<u>Bio Tek reMEDys, Inc.</u>	<u>L</u>	<u>49%</u>

List names of 4 largest partners and percentage of ownership:

Name: Arizona Hemophilia Association %: 51%Name: Bio Tek reMEDys, Inc. %: 49%

Name: _____ %: _____

Name: _____ %: _____

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:Monday thru Friday 9:00 am 5:00 pm MST Saturday x am x pmSunday x am x pm 24 Hours ON CALL

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, CHAITANYA GADDE

Responsible Person of AZBDBR, LLC dba AvasaRx 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

CHAITANYA GADDE

Print Name of Authorized Person

11/1/2018

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF DELAWARE)
NEW CASTLE COUNTY) ss.)

I, Chaitanya Gadde, 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 Authorized Signer for AZBDBR, LLC dba Avasa Rx (the Pharmacy), and in that capacity, I am authorized to speak on the Pharmacy's behalf.

2. I certify that upon licensure, the Pharmacy will not sell or ship compounded sterile products unto the state of Nevada, as indicated on the Pharmacy's application for a Nevada Out-of-State Pharmacy License.

3. I understand and acknowledge that the Pharmacy and any of its Nevada-registered/licensed staff members may be subject to discipline by the Board if the Pharmacy sells or ships any compounded sterile product into Nevada without first obtaining written authorization from the Board to do so.

4. I certify that if the Pharmacy ever decides to sell or ship any compounded sterile product into Nevada, the Pharmacy, through an authorized representative, will first notify the Board and obtain written approval to sell and ship such products into Nevada.

5. I understand that if the Pharmacy seeks approval to sell or ship compounded sterile product into Nevada, an authorized representative of the Pharmacy may be required to appear before the Board to answer questions before such approval is granted.

FURTHER AFFIANT SAYETH NOT.

I, Chaitanya Gadde, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

SUBSCRIBED AND SWORN TO
 before me, a notary public this
1st day of November, 2018.

Reeta Sharma
 NOTARY PUBLIC

Chaitanya Gadde
 Name





OWNERS

- AZ Hemophilia Assoc. 826 N. 5th Ave, Phoenix, AZ 85003 602-955-3947
- Bio Tek reMEDys, Inc. 2 Penns Way, Suite #404,
New Castle, DE 19720 302-544-5138

- | | <u>Pharmacist</u> | <u>License #</u> |
|--------------|---------------------------------------|------------------|
| • Ronak Modi | W. Portland Street, Phoenix, AZ 85003 | S023110 |

- | | <u>Pharmacy Technician</u> | <u>License #</u> |
|-------------------------|--|------------------|
| • Shelomith Adina David | 7 N. 47 th Dr., Phoenix, AZ 85031 | 10049494 |

AvasaRX
 816 N. 6th Ave. Phoenix, AZ 85003
 Tel: 844-482-2005
 Fax: 833-437-2301
www.avasarx.com



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: 10/02/2018
Receipt Number: 201843721
Receipt Amount \$: 240.00

Resident Pharmacy/Limited Service

Retail

Issued to :

PERMIT NO
Y007409
AZBDBR, LLC
816 N. 6TH AVE.
PHOENIX, AZ 85003

EXPIRES
10/31/2019
AvasaRx Pharmacy
816 N 6TH AVENUE
PHOENIX, AZ 85003

Kam Gandhi
EXECUTIVE DIRECTOR

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



WALLET CARD

JAME : AZBDBR, LLC
LICENSE NUMBER : Y007409
EXPIRES : 10/31/2019

<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. R4-23-01 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.

5B

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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☒ 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: One Choice Pharmacy

Physical Address: 2503 S. Main, Ste. D Stafford TX 77477

Mailing Address: 2503 S. Main Ste. D

City: Stafford State: TX Zip Code: 77477

Telephone: 281-969-7899 Fax: 346-341-7968

Toll Free Number: 800-505-1327 (Required per NAC 639.708)

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

Managing Pharmacist: Gerald E. Zimmerman License Number: 30404

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

☒ ☐ Retail

☐ ☒ Hospital (# beds _____)

☐ ☒ Internet

☐ ☒ Nuclear

☐ ☒ Ambulatory Surgery Center

☒ ☒ Community

☒ ☐ Other: NON-RESIDENT

All boxes must be checked

For the application to be complete

Yes/No

☐ ☒ Off-site Cognitive Services

☐ ☒ Parenteral **

☐ ☒ Parenteral (outpatient)

☐ ☒ Outpatient/Discharge

☒ ☐ Mail Service

☐ ☒ Long Term Care

☐ ☒ Sterile Compounding **

☐ ☒ Non Sterile Compounding

☐ ☒ Mail Service Sterile Compounding **

☐ ☒ 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.

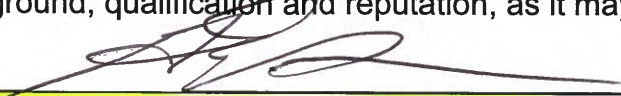
Within the last five (5) years:

- 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

Gerald E. Zimmerman / PIC
Print Name of Authorized Person

2/2/2019
Date

Page 2

Board Use Only

Date Processed: _____

Amount: 500.00

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: Universal Healthcare Network, LLC
 Business Name: One Choice Pharmacy
 Current Business Address: 2503 S. Main, Ste. 0
 City: Stafford State: TX Zip Code: 77477
 Telephone: 281-969-7899 Fax: 346-341-7968

List any physician shareholders and percentage of ownership.

Name: _____ %: _____
 Name: _____ %: _____
 Name: _____ %: _____
 Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 8 am 5 pm Saturday 9 am 3 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: _____

STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Gerald E. Zimmerman

Responsible Person of ONE CHOICE 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

Gerald E. Zimmerman / PIC

Print Name of Authorized Person

2/7/2019

Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF TEXAS)
HARRIS) ss.
COUNTY)

I, Gerald E. Zimmerman, 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 one choice 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, Gerald E. Zimmerman, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

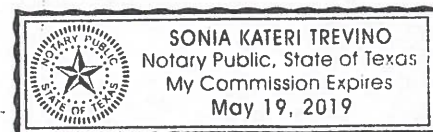
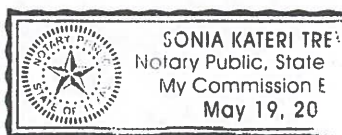


Name

SUBSCRIBED AND SWORN TO
before me, a notary public this
7th day of February, 2019.

Sonia K. Trevino
NOTARY PUBLIC

EXP: 5/19/19





RE: Pharmacy Staff List

Owned by Entity:

Universal Healthcare Network LLC
 2503 S. Main Street, Ste O
 Stafford, TX 77477
 FEIN: 82-190548

Corporate Officer:

Fathy ElSafty
 Windsor Lakes Dr.
 Houston, TX 77094
 DOB: . . . ,9
 SSN: . . .

Pharmacist In Charge

Gerald Zimmerman
 ----- Gondola Dr
 Stafford, TX 77477
 DOB: : . . .



Re: Non-Resident Pharmacy License Application

Universal Healthcare Network LLC (dba) One Choice Pharmacy is a retail/non-resident pharmacy that dispenses diabetic testing supplies and a handful of topical ointments, creams & gels. One Choice Pharmacy does not participate in Compounding Medications and does not dispense any Controlled Substances. If the pharmacy dispensing should change in any manner, all state board of pharmacies will be immediately notified.

For additional questions or concerns please email:

Onechoicepharmacy@gmail.com



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

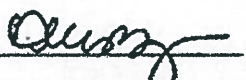
License No. **31986**

Expiration Date: **4/30/2020**

Balances: **0**

**ONE CHOICE PHARMACY
2503 S MAIN STE O
STAFFORD TX 77477**




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

MUST BE DISPLAYED IN FULL PUBLIC VIEW

5C

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)

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☒ **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: Soleo Health Inc.

Physical Address: 10210 Werch Drive, Suite 202

Mailing Address: Same

City: Woodridge State: IL Zip Code: 60517-4809

Telephone: (630) 589-8054 Fax: (877) 393-1616

Toll Free Number: (844) 575-1515 (Required per NAC 639.708)

E-mail: licensure@soleohealth.com Website: www.soleohealth.com

Managing Pharmacist: Jason Howard, PharmD License Number: 051.293255

TYPE OF PHARMACY

AND

SERVICES PROVIDED

Yes/No

- ☒ ☐ Retail
☐ ☒ Hospital (# beds ____)
☐ ☒ Internet
☐ ☒ Nuclear
☐ ☒ Ambulatory Surgery Center
☒ ☐ Community
☒ ☐ Other: Specialty

All boxes must be checked

For the application to be complete

Yes/No

- ☐ ☒ **Off-site Cognitive Services**
☐ ☒ **Parenteral ****
☐ ☒ Parenteral (outpatient)
☐ ☒ Outpatient/Discharge
☒ ☐ Mail Service
☒ ☐ Long Term Care
☐ ☒ **Sterile Compounding ****
☐ ☒ Non Sterile Compounding
☐ ☒ **Mail Service Sterile Compounding ****
☒ ☐ Other Services: IVIG, Factor

****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

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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

John Ginzler
Print Name of Authorized Person

January 30, 2019
Date

Page 2

Board Use Only

Date Processed: _____

Amount: 500.00

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: Delaware

Parent Company if any: NA

Mailing Address: 11 Trafalgar Square, Suite 101

City: Nashua State: NH Zip: 03063-1991

Telephone: (833) 765-3648 Fax: (603) 718-3824

Contact Person: Christine Belanger

For any corporation non publicly traded, disclose the following:

- ***No persons
- 1) List top 4 persons to whom the shares were issued by the corporation?
- a) Soleo Health Holdings, Inc. 100%
- 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? \$0.01/share par value
- 4) What date did the corporation actually receive the cash assets? 2/14/2014
- 5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: N/A %: _____

Name: N/A %: _____

Hours of Operation for the pharmacy:

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

Sunday On call am _____ pm 24 Hours 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, John Ginzler

Responsible Person of Soleo Health 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

John Ginzler
Print Name of Authorized Person

January 30, 2019
Date

AFFIDAVIT for Out-of-State Pharmacy License

STATE OF New Hampshire)
) ss.
Hillsborough COUNTY)

I, John Ginzler, 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 Chief Financial Officer for Soleo Health 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, John Ginzler, do hereby swear under penalty of perjury that the assertions of this affidavit are true.

SUBSCRIBED AND SWORN TO
 before me, a notary public this
 30th day of January, 2019.

Christine H. Belanger
 NOTARY PUBLIC

Name 



Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SOLEO HEALTH INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTEENTH DAY OF APRIL, A.D. 2018.

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

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "SOLEO HEALTH INC." WAS INCORPORATED ON THE TWENTY-FOURTH DAY OF FEBRUARY, A.D. 2014.

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



5486590 8300

SR# 20182683263

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

A handwritten signature of Jeffrey W. Bullock in black ink, written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Authentication: 202511191

Date: 04-13-18

1/29/2019

Print Lookup Details



Illinois Department of Financial and
Professional Regulation

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA
SOLEO HEALTH INC	Woodridge, IL 60517	

License

License Information

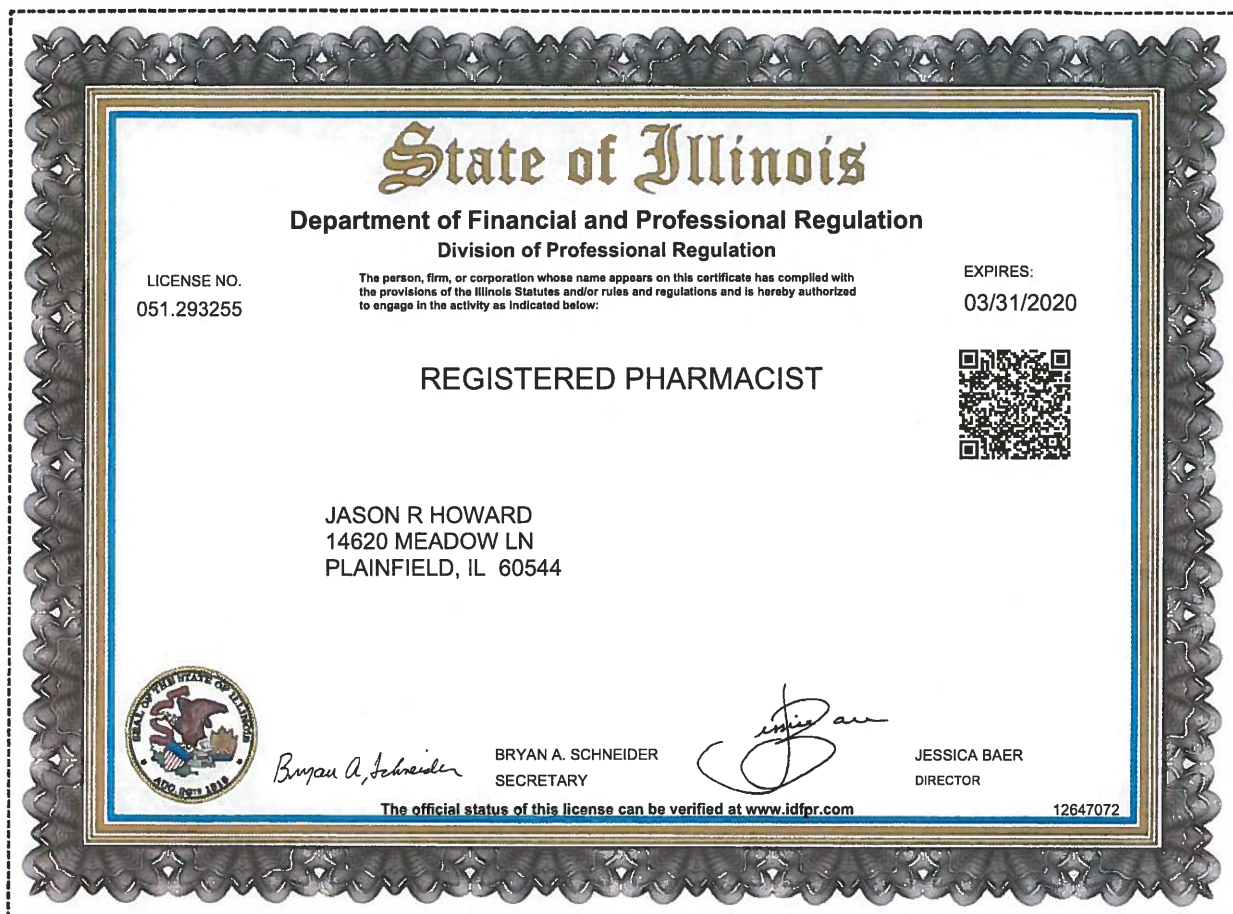
License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
054020894	LICENSED PHARMACY	ACTIVE	11/14/2018	11/14/2018	03/31/2020	N

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Soleo Health

Sharon Hill, PA

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

August 25, 2018

Accreditation is customarily valid for up to 36 months.


Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #574329
Print/Reprint Date: 10/19/2018


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

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