

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 1B02706
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: DESERT WINDS HOSPITAL, LLC

Physical Address: 5900 W. ROCHELLE AVENUE

City: LAS VEGAS

State: Zip Code: 89103

Telephone:

305-864-9191

Fax: 786-515-6770

Toll Free Number:

E-mail: ABRICKTURIN@DESERTWINDSHOSPITAL.COM

Website:

Managing Pharmacist: Vincent A. Pigula

License Number: NV 20440

TYPE OF PHARMACY AND

SERVICES PROVIDED

Yes/No

☐ ☒ Retail

☐ ☐ Hospital (# beds 154)

☐ ☒ Internet

☐ ☒ Nuclear

☐ ☒ Ambulatory Surgery Center

☐ ☒ Community

☐ ☐ Other: PRTF - 48 beds

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:

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

- 1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒
- 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒
- 3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☐
- 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒
- 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

If the answer to question 1 through 5 is "yes", a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.


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

ANDREW-BRICK TURIN

Print Name of Authorized Person

11/19/2020

Date

Board Use Only

Date Processed: _____

Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: DELAWARE

Parent Company if any: DESERT WINDS HOSPITAL HOLDINGS, LLC

Mailing Address: 10800 BISCAYNE BLVD SUITE 600

City: MIAMI State: FL Zip: 33161

Telephone: 305-864-9191 Fax: 786-515-6770

Contact Person: ANDREW BRICK-TURIN

For any corporation non publicly traded, disclose the following:

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

a) ABRAHAM SHAULSON 10800 BISCAYNE BLVD SUITE 600, MIAMI FL, 33161

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. n/a

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

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 8:00 am 2:30 pm

Saturday 10:00 am 2:00 pm

Sunday 10:00 am 2:00 pm

24 Hours _____

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

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

I, ANDREW BRICK-TURIN

Responsible Person of DESERT WINDS HOSPITAL, 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

ANDREW BRICK-TURIN

Print Name of Authorized Person

11/19/2020

Date

Managing Pharmacist

Pharmacist Name: VINCENT A. FIGULA

NV License #: 20440

Pharmacy Name: DESERT WINDS HOSPITAL PHARMACY

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. been the subject of a board citation or an administrative action whether completed or pending in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

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

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

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

Signature Vincent A. Rigoli

Date 11/19/2020

for a Pharmacy or Wholesaler located in Nevada

✓ Date

11/19/2020

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 herein 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 DESERT WINDS HOSPITAL PHARMACY
5900 W. ROACHELLE AVE, LAS VEGAS, NV 89103
Nature of Pharmacy or Wholesaler
Name and Address of Business for Which Designated Representative Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name PIGULA First Name VINCENT Middle Name ALAN

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

N/A

Present Residence Address-Street or RFD City State/Zip

4ARTLEY AVE DATES HENDERSON, NV 89052 SINCE 3/2019

Present Business Address City State/Zip

N/A

Present Position with the Pharmacy or Wholesaler Dates Phone: Residence Business

Date of Birth 69 Place of Birth (City, County, State) SYRACUSE, MONROE, NY

Age 69 Social Security Number M Sex M

Color of Eyes BROWN Color of Hair WHITE Complexion FAIR Weight 270 Build L Height 6'00"

Scars, tattoos or distinguishing marks and/or characteristics N/A

Are you a citizen of the United States? Yes ☒ No ☐ If alien, registration No.

If naturalized, certificate No. Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☒ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial VAB

A. **Current Marriage** 9/16/1979
 Date
 Spouse's full name (Maiden) KATHY JEAN MARY City, County and State GENEVA NY
 Date of Birth _____ Place of Birth GENEVA NY
 Resident address HARTLEY AVE, HENDERSON NY 14052
 Street City State Zip
 Telephone: Residence _____ Business _____
 Spouse's employer ADVANCED PHARMACEUTICAL CONSULTANTS, PHARMACEUT
 Occupation
 Address of employer SEVEN HILLS HOSP, 3021 WEST HORIZON RIDGE PK
 Street City State Zip
HENDERSON, NY 14052

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
NA				

List of names, current address and telephone numbers of previous spouses:

Name	Street	City	State	Zip	Telephone

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
NA			

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 VAT

District attorney or public agency responsible for enforcing the child support order:

Name

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
ALL DECEASED			

Father

ALBERT G. PIGULA, DEVOE ROAD, CAMILLUS, NY 13031 STEELWORKER

Mother

HELEN J. PIGULA, " " " " HOMEMAKER

Father-in-Law

ROBERT A. MACEY, Washington St Canaan NY 14429 CPA

Mother-in-Law

ALICE M. MACEY " " " " ADMINISTRATIVE ASSISTANT

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
DAVID PIGULA, DECEASED		MORAVIA, NY	TRUCK DRIVER
SANDY BAKER		MORAVIA, NY	ASSEMBLER
KATHY PIGULA BAKER		MONTE CARLO, LA	Retired Nurse
CHARLES BAKER		SYRACUSE, NY	Retired TRUCK DRIVER
Peter D. Pigula		CAMILLUS, NY	Retired TRUCK DRIVER
LOLAINE DUTTON		CAMILLUS, NY	Retired Social Worker
MARK PIGULA		CAMILLUS, NY	FARMER
CECELIA PIGULA		CAMILLUS, NY	HOMEMAKER
STEPHANIE PIGULA PUTNEY		HANALATON, NY	SCHOOL TEACHER - DECEASED
HOWARD PUTNEY		"	Retired School Teacher

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School	WARRERS ELEM SC WARRERS NY	9/56-5/61	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School	WEST GENESSEE JR SR HS. CAMILLUS, NY	9/61-5/69	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College	ALBANY COLLEGE OF PHARMACY, ALBANY NY	9/69-5/74	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
University	ALBANY COLLEGE OF PHARMACY, ALBANY NY	9/69-5/74	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other	MANCHESTER INSTITUTE OF TECHNOLOGY, ROCHESTER NY	9/75-5/82	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any..... DOCTORAL DEGREE IN PHARMACY

College or university where obtained..... MASTERS OF HEALTH SYSTEMS ADMINISTRATION

Applicant's initial..... VAD

A. Have you ever served in any armed forces? Yes ☐ No ☒

Branch Date of entry-active service

Date of separation Type of discharge

Rating at separation Serial number

While in the military service were you ever arrested for an offense which resulted in summary action, a trial or special or general court martial? Yes ☐ No ☐ If yes, furnish details on page 10. (List all incidents regardless of where they occurred-foreign or domestic.)

B. Have you registered for the draft? Yes ☒ No ☐

County OSHAUDOGA State NY Date registered 2/1969

6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.)

A. Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or violation for any reason whatsoever, regardless of the disposition of the event? (Except minor traffic citations.) Yes ☐ No ☒ If yes, give details in space provided below. List all cases without exception.

Date of Arrest	Age	Charge	Location-City and State	Deposition/Date	Arresting Agency

B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes ☐ No ☒ If yes, furnish details on page 10.

C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes ☐ No ☒

D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes ☐ No ☒

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

Applicant's initial WAS

- 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
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- 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
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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
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3/2019 Present HARTLEY AVE, HENDERSON NY 89052

12/1985 - 3/2019 15 WENLOCK ROAD, FAIRPORT, NY 14450

Applicant's initial

WHD

A designated representative must document that he or she has been employed for at least 6,000 hours in pharmacies or wholesalers in a capacity related to the dispensing and distribution of and record keeping related to prescription drugs. Please provide the following information to document your hours of employment.

Month and Year 6/1974-1982	Name/Mailing Address of Employer/Business KEY/PAY DRUGS Rochester NY	Number of Employed Hours 40
Title SUPERVISING PHARMACIST	Description of Duties	Name of Supervisor CARMEN ROSSI
Month and Year 1982-2009	Name/Mailing Address of Employer/Business ELI LILLY, INDIANAPOLIS IN. 46285	Number of Employed Hours 40
Title SALES REPRESENTATIVE - DETAIL MAN	Description of Duties	Name of Supervisor MICHAEL NELSON
Month and Year 8/1989-5-1998	Name/Mailing Address of Employer/Business FINCH LAKE POISON CONTROL	Number of Employed Hours 12
Title SPECIALIST IN POISON INFORMATION	Description of Duties	Name of Supervisor RUTH LAWRENCE, MD
Month and Year 8/1989-2010	Name/Mailing Address of Employer/Business MILLER'S PHARMACY, FARMINGTON NY	Number of Employed Hours 12
Title RETAIL PHARMACIST	Description of Duties	Name of Supervisor DAN MILLER
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	Description of Duties	Name of Supervisor

If additional space is needed, continue on page 10 or provide attachment.

V. 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	City	State	Zip	Telephone	Years Known
Name <u>JOANNE LAURITO,</u>	Home <u>5 WAIGHT ST</u>	<u>LAKEVIEW, NY</u>	<u>11223</u>		<u>30</u>
Employer <u>AAC</u>	Business <u>SEVEN HILLS HOSPITAL</u>	<u>PHARMACIST IN CHARGE</u>			
Name <u>PHILIP J. MONTANAN</u>	Home <u>MILFORD CROSSING,</u>	<u>PENFIELD NY</u>	<u>14526</u>		
Employer <u>Retired</u>	Business <u>PHARMACIST</u>				
Name <u>SCOTT TUCKER</u>	Home <u>7 VICTOR BLVD</u>	<u>NY</u>			<u>10 YRS</u>
Employer <u>STRONG HOSPITAL</u>	Business <u>- PHARMACY</u>	<u>GREECE, NY</u>			
Name <u>JUSTIN ACKER</u>	Home <u>SEE</u>				
Employer <u>NURSING HOME</u>	Business <u>PHARMACY</u>	<u>HE IS A PHARMACIST 10 YRS</u>			
Name <u>TAMMY BEDGETT</u>	Home <u>SEE</u>	<u>PALM SPRING</u>			
Employer	Business <u>PHARMACY</u>	<u>TECHNICAL TECH</u>			

10. Have you ever held a privileged, occupational or professional license in any state, including but not limited to the following:

Liquor	Lawyer	Race horse/race dog owner	Securities dealer	Insurance
Doctor	Contractor	Real estate broker or salesman	Barber/Cosmetologist	Gaming
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☐

If yes, state type, where and years held

LICENSED TO PRACTICE PHARMACY IN NEW YORK
3/1975 TO PRESENT 029299

11. Have you ever applied for a city, county or state business, venture or industry license or held a financial interest in a licensed business or industry OUTSIDE the State of Nevada? Yes ☐ No ☒
If yes, state type, when and where and give names and locations of the businesses in which you were involved, the names and address of all partners and the agency responsible for licensing said business, venture or industry.

12. Have you ever appeared before any licensing agency or similar authority in or outside the State of Nevada for any reason whatsoever? Yes ☐ No ☒

13. Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes ☐ No ☒

If yes to the above, state where, when and for what reason:

Applicant's initial UAF

participant in any group which has been denied a business or industry license or related finding of suitability or been a
suitability?

Yes ☐ No ☒

15. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry?

Yes ☐ No ☒

16. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances?

Yes ☐ No ☒

17. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a wholesaler)

Yes ☐ No ☒

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry?

Yes ☐ No ☒

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler?

Yes ☒ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler?

Yes ☒ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours?

Yes ☒ No ☐

ATTACH PHOTOGRAPH

TAKEN

30 DA



Date of photograph

11/19/2020

Applicant's initial

VAP

Page 8

COUNTY OF Miami-Dade

I, VINCENT A. PIGULA, 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 cause for denial or revocation of a wholesaler license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or wholesaler in the State of Nevada.

Vincent Pigula
Original Signature of Applicant

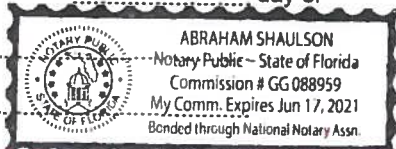
Subscribed and Sworn to before me this

20th

day of

November 2020

Notary Public



(seal)

Applicant's initial

VAP

Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DESERT WINDS HOSPITAL LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE EIGHTEENTH DAY OF NOVEMBER, A.D. 2020.

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



4107761 8300

SR# 20208441426

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

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

Authentication: 204115156

Date: 11-18-20

DESERT WINDS HOSPITAL, LLC
PHARMACY

List of Designated Officers:

1. CEO – Pending
2. CFO – Andrew Brick-Turin

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 11/20/2020

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 herein 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 Pharmacy
Nature of License
Desert Winds Hospital, LLC
Name and Address of Establishment for Which License Is Requested
Montevista Hospital, LLC
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Brick-Turin
Last Name
N/A
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)
South Ocean Drive, Apt.
Present Residence Address-Street or RFD
Hallandale
City
FL, 33009
State/Zip
10800 Biscayne Blvd, Suite 600
Present Business Address
Dates 10/2015 - Present
Miami
City
FL, 33161
State/Zip
CFO
Occupation
Dates 04/2016 - Present
Phone:
Residence
Business (305)864-9191
Arlington, Arlington, Virginia
Date of Birth
Place of Birth (City, County, State)
33
Age
Social Security Number or ITIN
Male
Sex
Blue
Brown
White
150 lbs
Average
5'8
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

AB

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MARITAL INFORMATION-Continued

A. Current Marriage June 2, 2014 Miami, Miami-Dade, FL
 Date City, County and State
 Spouse's full name (Maiden) Melanie Laoui SS# or ITIN
 Date of Birth _____ Place of Birth Buenos Aires, Argentina
 Resident address South Ocean Drive, Apt. Hallandale FL 33009
 Street City State Zip
 Telephone: Residence _____ Business N/A
 Spouse's employer N/A Occupation Homemaker
 Address of employer N/A
 Street City State 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
Ariela Brick-Turin		Miami Beach, FL	South Ocean Drive, Apt. Hallandale, FL, 33009
Daniela Brick-Turin		Miami Beach, FL	South Ocean Drive, Apt. Hallandale, FL, 33009

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 AB

FAMILY INFORMATION-Continued

District attorney or public agency responsible for enforcing the child support order:

Name N/AAddress N/AContact 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
Alan Brick-Turin Father		Collins Ave, Apt. 2807, Miami Beach, FL 33140	Engineer
Carol Brick Mother		Collins Ave, Apt. 2807, Miami Beach, FL 33140	Retired
Victor Eduardo Laoui Father-in-Law		Av. Libertador, Buenos Aires, Argentina	Real Estate
Luisa Irene Hallack Mother-in-Law		Av. Libertador, Buenos Aires, Argentina	Homemaker

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
Jocelyn Brick-Turin Spouse		Tardish, Modiin, Israel	Software
Joshua Ben-David Spouse		Tardish, Modiin, Israel	Product Manager
Spouse			
Spouse			
Spouse			

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate	
Grammar School	Gesher JDS	Fairfax, VA	1993 - 2000	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School	WT Woodson HS	Fairfax, VA	2001 - 2005	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University	University of Southern California	Los Angeles, CA	2005 - 2010	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other	University of Miami	Coral Gables, FL	2011 - 2012	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any B.S. Accounting, M.S. TaxationCollege or university where obtained University of Miami, University of Southern California

Applicant's initial

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5 MILITARY INFORMATION:

A. Have you ever served in any armed forces?

Yes ☐ No ☒Branch N/A Date of entry-active service N/ADate of separation N/A Type of discharge N/ARating 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 Fairfax State VA Date registered 2005**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
2005	18	Drunk in Public	Spotsylvania, VA	2005	Spotsylvania Sheriff

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				
N/A				
N/A				

Applicant's initial

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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
04/2016 - Present	South Ocean Drive, Apt.	Hallandale	FL, 33009
08/2005 - 04/2016	4775 Collins Ave, Apt. 2807	Miami Beach	FL, 33140
04/1987 - 08/2005	4724 Springbrook Dr.	Annandale	VA, 22003

Applicant's initial AK

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.

October 2015 - Present	Millennium Management, LLC - 10800 Biscayne Blvd, Suite 600, Miami, FL 33161	N/A
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
CFO	Financial Reporting and Accounting	Abraham Shaulson
Title	Description of Duties	Name of Supervisor
June 2019 - Present	Southern Winds Hospital, LLC - 4225 W 20th Ave, Hialeah, FL 33012	N/A
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
CFO	Financial Reporting and Accounting	Abraham Shaulson
Title	Description of Duties	Name of Supervisor
June 2016 - June 2019	Southern Winds Health, LLC - 4225 W 20th Ave, Hialeah, FL 33012	Change of Ownership
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
CFO	Financial Reporting and Accounting	Abraham Shaulson
Title	Description of Duties	Name of Supervisor
May 2012 - October 2015	Berkowitz Pollack Brant Accountants & Advisors - 200 S Biscayne Blvd 6th Floor, Miami, FL 33131	Took Position at Millennium
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
CFO	Taxation	Joseph Saka
Title	Description of Duties	Name of Supervisor
August 2010 - May 2011	Reliant Financial Corp. - 2575 W Woodland Dr, Anaheim, CA 92801	Moved
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Intern	Administrative	Matthew Schnablegger
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

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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
<u>Name</u> Mordy Goldenberg	<u>Home</u>	East 31st Street, Brooklyn, NY 11234				Five
<u>Employer</u> Wilk Auslander, LLP	<u>Business</u>	1515 Broadway, 43rd Floor, New York, NY 10036			(212)981-2325	
<u>Name</u> Isaac Benmergui	<u>Home</u>	Froude Avenue, Surfside, FL 33154				Five
<u>Employer</u> Isaac Benmergui Law Offices	<u>Business</u>	10800 Biscayne Blvd #650, Miami, FL 33161			(305)397-8547	
<u>Name</u> Jordan Kaplan	<u>Home</u>	Quayside Towers, Miami Shores, FL 33138				Five
<u>Employer</u> The Bernstein Law Firm	<u>Business</u>	3050 Biscayne Blvd #403, Miami, FL 33137			(305)672-9544	
<u>Name</u> Rabbi Leibel Kudan	<u>Home</u>	Seacrest Parkway, Hollywood, FL 33019				Five
<u>Employer</u> Chabad Ocean Drive	<u>Business</u>	Seacrest Parkway, Hollywood, FL 33019			(954)801-3367	
<u>Name</u> Ira Silver	<u>Home</u>	Collins Ave, Surfside, 33154				Ten
<u>Employer</u> Hidden Gems Life Insurance	<u>Business</u>	4000 Hollywood Blvd, Suite 520N, Hollywood, FL 33021			(954)500-5433	

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
N/A			
N/A			

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
<u>Accountant</u>	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☒ No ☐

If yes, state type, where and years held

CPA, California 2012 - Present

12. Have you ever applied for a city, county or 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.

Applicant's initial

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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:

N/A

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 ☒

N/A

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 Nov, 10th, 2020

Applicant's initial AB

STATE OF Florida

SS.

COUNTY OF Miami Dade

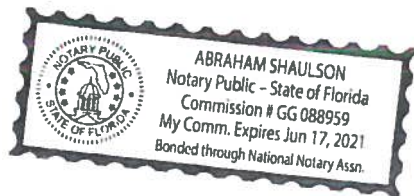
I, Andrew Brick-Turn, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause 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 or 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.

[Signature]
Original Signature of Applicant

Subscribed and Sworn to before me this 20th day of November

[Signature]
Notary Public



(seal)

Applicant's initial AB