NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☑ New Pharmacy ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: PH_____)

☐ Publicly Traded Corporation □ Pages 1,2,3,7,8a,8b ☐ Partnership - Pages 1,2,5,7,8a,8b
☑ Non Publicly Traded Corporation □ Pages 1,2,4a,4b,7,8a,8b ☐ Sole Owner □ Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Direct Compounding and Outsourcing, LLC

Physical Address: 1850 Whitney Mesa Blvd, Suite 180

Mailing Address: 1850 Whitney Mesa Blvd, Suite 180

City: Henderson State: NV Zip Code: 89014

Telephone: **702-877-0703** Fax: 702-342-0335

Toll Free Number: 888-341-0157

E-mail: egerber@directcompounding.com Website: _____

Managing Pharmacist: Tim Brown License Number: 13529

Hours of Operation:

Monday thru Friday 9 am 5 pm Saturday - am - pm

Sunday - am - pm 24 Hours -

TYPE OF PHARMACY

- ☑ Retail
- ☐ Hospital (# beds ____)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☐ Ambulatory Surgery Center

SERVICES PROVIDED

- ☐ Off-site Cognitive Services
- ☐ Parenteral
- ☐ Parenteral (outpatient)
- ☐ Outpatient/Discharge
- ☐ Mail Service
- ☐ Long Term Care

99103

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 or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

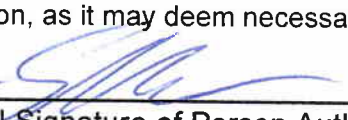
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☑

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☑

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

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

Ellie Gerber
Print Name of Authorized Person

10-15-2017
Date

Board Use Only Received: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: _____

Corporation Name: Direct Compounding and Outsourcing, LLC

Mailing Address: 1850 Whitney Mesa Drive, Suite 180

City: Henderson State: NV Zip: 89014

Telephone: 702-877-0703 Fax: 702-342-0335

Contact Person: egerber@directcompounding.com

For any corporation non publicly traded, disclose the following:

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

a) Olympia Management, LLC 1850 Whitney Mesa Dr, Suite 180, Henderson, NV 89014
Name Address

b) Ellie Gerber 1850 Whitney Mesa Dr, Suite 180, Henderson, NV 89014
Name Address

c) _____
Name Address

d) _____
Name Address

NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the New Applications tab. The forms are available under the *documents for all types of businesses*.

2) Provide the number of shares issued by the corporation. 500

3) What was the price paid per share? Ø Par Value

4) What date did the corporation actually receive the cash assets? 10/4/2017

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

List any physician shareholders and percentage of ownership.

Name: David Smith %: 76.5%

Name: _____ %: _____

STATATEMENT OF RESPONSIBILITY - Pharmacy
For Corporations, Partnership or Sole Owners

I, David J Smith

Responsible Person of Direct Compounding and outsourcing

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 company.

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 or operation of a pharmacy in Nevada.

I further acknowledge and understand that upon the change of managing pharmacist in the pharmacy, the owners must assure that an accountability audit of all controlled substances shall be performed jointly by the departing managing pharmacist and the new managing pharmacist.

David J Smith

Original Signature, no stamps or copies

11/8/2017

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Timothy Brown License #: 13529

Pharmacy Name: Direct Compounding

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 an administrative action whether completed or pending in any state?	☒	☐
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☒

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

Board Administrative Action: State: NV Date: 2011 Case #: 11-092C-RPH-S

And/or Criminal Action: State: _____ Date: _____ Case #: _____

County _____ Court: _____

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

1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practioners 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.

Original Signature, no stamps or copies

10/4/2017
Date

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☑ New Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ 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: RENO BEHAVIORAL HEALTHCARE HOSPITAL

Physical Address: 6940 SIERRA CENTER PARKWAY

City: RENO State: NV Zip Code: 89511

Telephone: 702-305-9858 Fax: NOT AVAILABLE

Toll Free Number: NOT AVAILABLE E-mail: STEVE.SHELL@RENOBEHAVIORAL.COM

Website: RENOBEHAVIORAL.COM

Managing Pharmacist: MURRAY ROBISON License Number: 13867

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☑ Retail	☐	☑ Off-site Cognitive Services
☑	☐ Hospital (# beds 124)	☐	☑ Parenteral
☐	☑ Internet	☐	☑ Parenteral (outpatient)
☐	☑ Nuclear	☐	☑ Outpatient/Discharge
☐	☑ Ambulatory Surgery Center	☐	☑ Mail Service
☐	☑ Community	☐	☑ Long Term Care
☐	☑ Other: _____	☐	☑ Sterile Compounding
		☐	☑ Non Sterile Compounding
All boxes must be checked		☐	☑ Mail Service Sterile Compounding
For the application to be complete		☐	☑ Other Services: _____

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

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

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☑

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

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

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

Steve Shell

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

Steve Shell

Print Name of Authorized Person

12-12-17

Date

Board Use Only	Date Processed: _____	Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION LIMITED LIABILITY COMPANY

State of Incorporation: NEVADA

Parent Company if any: SIGNATURE HEALTHCARE SERVICES, LLC

Mailing Address: 1450 W. LONG LAKE RD STE 340

City: TROY State: MI Zip: 48098

Telephone: 248-905-5091 Fax: 248-905-5096

Contact Person: HANA ATTAR

For any corporation non publicly traded, disclose the following:

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

a) SIGNATURE HEALTHCARE SERVICES 1450 W LONG LAKE RD. STE 340, TROY, MI 48098
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 %: _____

Name: _____ %: _____

Hours of Operation for the pharmacy:

Monday thru Friday 9 am 12 pm Saturday 9 am 12 pm

Sunday 9 am 12 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 – Nevada Pharmacy
FOR Corporations, Partnership or Sole Owners

I, Steve Shell

Responsible Person of Reno Behavioral Healthcare 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.

Steve Shell

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

Steve Shell

Print Name of Authorized Person

12-12-17

Date

Pharmacy Application – List of Officers

Officer Information for **Reno Behavioral Healthcare Hospital, LLC**

EIN: 81-3526906

Title	Name	Address
CEO	Steve Shell	6940 Sierra Centre Parkway, Reno, NV 89511
Pharmacy Manager	Murray Robison	6940 Sierra Centre Parkway, Reno, NV 89511

Officers/ Directors of **Signature Healthcare Services, LLC**

EIN: 38-3544748

Title	Name	Address
Manager/Member/President	Soon K. Kim	1450 W. Long Lake Road, Suite 340 Troy, MI 48098
Executive Vice President	Blair Stam	2065 Compton Avenue Corona, CA 92881
SVP/ General Counsel	Laura Sanders	1450 W. Long Lake Road, Suite 340 Troy, MI 48098
SVP/ Chief Financial Officer	Cory Delello	2065 Compton Avenue Corona, CA 92881

Managing Pharmacist

Pharmacist Name: MURRAY ROBISON License #: 13867

Pharmacy Name: RENO BEHAVIORAL HEALTHCARE HOSPITAL

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.

Signature _____ Date 12/12/2017

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy

(**non-refundable** and **not transferable money order or cashier's check only**)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH____
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ 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: WEST VALLEY PHARMACY

Physical Address: 6125 WEST SAHARA AVE. #1A

City: LAS VEGAS State: NV Zip Code: 89146.

Telephone: 702-330-9836. Fax: (702) 330-9761

Toll Free Number: NA E-mail: WESTVALLEYPHARMACY@YAHOO.COM.

Website: NA

Managing Pharmacist: Louis X. NGUYEN License Number: 14721

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: _____

99243

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

Louis X. Nguyen
Print Name of Authorized Person

11/27/17
Date

Board Use Only Date Processed: _____ Amount: $500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: SAHARA LIMITED GROUP L.L.C.

Mailing Address: 2885 RED SPRING DR.

City: LAS VEGAS State: NV Zip: 89135.

Telephone cell 714-642-1514 OR 702-330-9836 Fax: (702)330-9761.

Contact Person: Louis X. NGUYEN

For any corporation non publicly traded, disclose the following:

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

a) Louis X. NGUYEN 6125 WEST SAHARA AVE #1A LAS VEGAS. NV 89146
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. 1000

3) What was the price paid per share? $10.00 US. DOLLARS.

List any physician shareholders and percentage of ownership.

Name: N/A %:

Name: N/A %:

Hours of Operation for the pharmacy:

Monday thru Friday 9:00 am 7:00 pm Saturday 9:00 am 3:00 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

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

I, LOUIS X. NGUYEN

Responsible Person of WEST VALLEY 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

LOUIS X. NGUYEN
Print Name of Authorized Person

11/27/17
Date

Managing Pharmacist

Pharmacist Name: Louis X. NGUYEN License #: 14721

Pharmacy Name: WEST VALLEY 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?	☐	☒
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.

Signature _____ 11/27/17
Date

APPLICATION TO BE THE DESIGNATED REPRESENTATIVE for a Pharmacy or Wholesaler located in Nevada

Date 11/27/17

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 RETAIL PHARMACY
Nature of Pharmacy or Wholesaler

WEST VALLEY PHARMACY-6125 WEST SAHARA AVE. # 1A. LAS VEGAS, NV. 89146
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	First Name	Middle Name
NGUYEN	LOUIS	XUAN

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

RED SPRINGS DR.	LAS VEGAS	NV 89135
Present Residence Address-Street or RFD	City	State/Zip
31571 CANYON ESTATES DR# 118	Dates 06/2008-PRESENT LAKE ELSINORE	CA 92530
Present Business Address	City	State/Zip
PHARMACIST	Dates 06/2008-PRESENT	
Present Position with the Pharmacy or Wholesaler		Phone:

Residence:

Business: 951-245-4488

DANANG/VIETNAM
Date of Birth — Place of Birth (City, County, State)

49
Age — Social Security Number — Sex

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
BROWN	BLACK	BROWN	150LBS.	MEDIUM/SMALL	5.5 FT.

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 LOS ANGELES, CA. (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage** 06/12/2004 (Date) BREA, CA. (City, County and State)

Spouse's full name (Maiden) VANHONG BUITRAN S.S. No.

Date of Birth Place of Birth SAIGON/VIETNAM

Resident address EVANSLN.PLACENTIA, CA 92870 (Street / City / State / Zip)

Telephone: Residence Business 951-245-4488

Spouse's employer LAKE VIEW PHARMACY Occupation PHARMACIST

Address of employer 31571 CANYON ESTATES DR.# 118 LAKE ELSINORE, CA 92530 (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
TRANG VU NGUYEN	08/1995	06/1992	DIVORCE	FOUNTAIN VALLEY, CA

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

Name	Street	City	State	Zip	Telephone
I DO NOT HAVE CURRENT INFORMATION					

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
TYLER NGUYENBUI		FOUNTAIN VALLEY, CA	EVANS LN. PLACENTIA, CA 92870
HENRY NGUYENBUI		GARDEN GROVE, CA	EVANS LN. PLACENTIA, CA 92870

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 NA.

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			
JOHN XUAN NGUYEN		PURDY ST. MIDWAY CITY, CA 92655	RETIRED.
Mother			
TAM T. NGUYEN		COCKATOO LN GARDEN GROVE CA.92841	RETIRED
Father-in-Law			
DZUAN BUI	DECEASED.		
Mother-in-Law			
THANH T. TRAN		LANDMARK LN. BREA, CA 92823.	RETIRED

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
TRINH XUAN NGUYEN		STANFORD AVE. LA MESA, CA 91942	ATTORNEY/SELF EMPLOYED
Spouse			
THANH T. NGUYEN		STANFORD AVE. LA MESA, CA 91942,	RESTAURANT MGR.
NGHIA XUAN NGUYEN		N. PAULINA AVE. REDONDO BEACH, CA 90277	MD.
Spouse			
TU C. NGUYEN		N. PAULINA AVE. REDONDO BEACH, CA90277	PHARMACIST.
JESSICA T. NGUYEN		PEACEFULL GROVE, LAS VEGAS, NV 89135	PHARMACIST.
Spouse			
PHUONG T. NGUYEN		SUMMERTINE LN. CULVER CITY, CA 90230	SOFRWARE ENGINEER
Spouse			
DAVID SUSSELL JOEL DENTON		SUMMERTINE LN. CULVER CITY, CA 90230	ATTORNEY

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar PHAN DINH PHUNG	VIETNAM	1981	Yes ☒ No ☐
High School MARIE CURIE HS	VIETNAM	1985	Yes ☒ No ☐
College ORANGE COAST COLLEGE	COSTA MESA, CA	1991-1994	
University UNIVERSITY OF SANTA BARBARA, CA.		1994- 1995	Yes ☐ No ☒
Other ALBANY COLLEGE OF PHARMACY, NY		1996-1999	Yes ☒ No ☐

Type of degree obtained, if any BS. PHARMACY

College or university where obtained ALBANY COLLEGE OF PHARMACY, NY

Applicant's initial

5 MILITARY INFORMATION:

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

Branch ..... Date of entry-active service .....

Date of separation ..... Type of discharge .....

Rating at separation ..... Serial number .....

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

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

County ORANGE State CA Date registered 06/25/1985 (ESTIMATE)

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
NA.					

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
NA				

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
NA.				

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
NA.		

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
04/1985-10/1989	7782 BARTON DR. # 2	HUNTINGTON BEACH,	CA 92647 (ESTIMATED)
11/1989-5/1995	14611 PURDY ST.	MIDWAY CITY,	CA 92655 (ESTIMATED)
06/1995-07/1996	SANTA BARBARA HOUSING, U.C.	SANTA BARBARA,	CA 93107(ESTIMATED)
08/1996-06/1999	255 NEW SCOTLAND AVE,	ALBANY,	NY 12208 (ESTIMATED)
7/1999 12/1999-	LIVING IN HENDERSON,	LAS VEGAS,	NV. (LOST THE EXACT ADDRESS) (ESTIMATED)
1/2000-11/2003	14611 PURDY ST.	MIDWAY CITY,	CA 92655 (ESTIMATED)
12/2003-12/2004	1260 E LA PALMA Av # J,	Anaheim	92805 (ESTIMATED)
12/2004-PRESENT	EVANS LN.	PLACENTIA,	CA 92870

Applicant's initial ..... W .....

8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
09/2008-PRESENT	LAKE VIEW PHARMACY 31571 CANYON ESTATES DR. #118 LAKE ELSINORE, CA92530	40HRS./WEEK.
Title	**Description of Duties**	**Name of Supervisor**
PHARMACIST	PHARMACY MANAGER	N.A

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
09/2001-08/2008	RALPHS PHARMACY 1121 N. HARBOR BLVD. FULLERTON,CA92832	40 HRS./WEEK.
Title	**Description of Duties**	**Name of Supervisor**
PHARMACIST	PHARMACY MANAGER	MARTIN OTSU

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
12/1990-8/2001	CVS PHARMACY FLOATER IN CA. AND NV.	40 HRS./WEEK.
Title	**Description of Duties**	**Name of Supervisor**
PHARMACIST	STAFF PHARMACIST/FLOATER	JOHN

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**

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
Title	**Description of Duties**	**Name of Supervisor**

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

Applicant's initial ....

9. CHARACTER REFERENCES:

List five character reference who have know you five years or more. Do not include relatives, present employer or employees.

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name KHAI TRAN	Home	3 CAITLIN ST. FULLERTON, CA 92832			382	10 YEARS.
Employer KAISER PERMANANTE	Business PHARMACIST					
Name KEVIN NGUYEN	Home	2 TRIDENT LN. HUNTINGTON BEACH, CA 92646			3	15 YEARS.
Employer SELF-EMPLOYED	Business MD.					
Name KHAI VU	Home	Warner Ave # 411, Fountain Valley, CA 92708			7	15 YEARS
Employer SELF-EMPLOYED	Business MD.					
Name Linh Daravong	Home	Starwood Dr Garden Grove CA 92840				6 YEARS
Employer TITLE PREPRESENTATIVE	Business Provident Title					
Name Joseph D. Nguyen	Home	Westminster Blvd. #66 Westminster, CA 92683				6 YEARS
Employer RE. BROKER	Business CRE Real Estate & Mortgage					

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

LIFE INSURANCE AGENT CA. 2008, CALIFORNIA REAL ESTATE BROKER 2007

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

VAN LOU INVESTMENTS, INC. 31571 CANYON ESTATES DR. # 120 LAKE ELSINORE, CA 92532

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:

N/A.

Applicant's initial

14. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability?
Yes ☐ No ☒

15. Have you or any person with whom you have been a participant in any group been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

16. Have you or any person with whom you have been a participant in any group ever been found guilty, plead guilty or entered a plea of nolo contendere to any offense, federal or state, related to prescription drugs and/or controlled substances?
Yes ☐ No ☒

17. Have you or any person with whom you have been a participant in any group ever surrendered a license, permit or certificate of registration relating to the pharmaceutical industry voluntarily or otherwise (other than upon voluntary close of a wholesaler
Yes ☐ No ☒

18. Do you have any relatives within the fourth degree of consanguinity associated with or employed in the pharmaceutical or drug related industry?
Yes ☒ No ☐

SISTER AND SISTER IN LAW ARE PHARMACISTS.

19. Will you be actively involved in and aware of the daily operation of the pharmacy or wholesaler?
Yes ☒ No ☐

20. Will you be employed fulltime with the pharmacy or wholesaler? Yes ☒ No ☐

21. Will you be present at the site of the pharmacy or wholesaler during its normal operating hours?
Yes ☒ No ☐

Date of photograph 11/15/2017

Applicant's initial

STATE OF CALIFORNIA

ss.

COUNTY OF Riverside

I, Louis X. NGUYEN, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a wholesaler license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false of fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Wholesaler and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Wholesaler as promulgated thereunder and agree, if licensed, to abide thereby,

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

Original Signature of Applicant

Subscribed and Sworn to before me this ..... day of

.....

See Attachment

Notary Public

(seal)

Applicant's initial