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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA PHARMACY LICENSE

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

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

Application must be printed legibly or typed

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

☒ New Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH_____

Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.

☐ Publicly Traded Corporation – Pages 1,2,3,10,11a&b
☐ Partnership - Pages 1,2,6,10,11a&b
☒ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b
☐ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: ATLANTIC PHARMACY

Physical Address: 2815 W. LAKE MEAD BLVD, SUITE 109

City: NORTH LAS VEGAS State: Zip Code: 89032 Telephone:

702-241-9653 Fax: 702-346-1718 Toll Free Number:_____

E-mail: atlanticpharmacylv@gmail.com

Website: www.atlanticrx.com

Managing Pharmacist: EMMANUEL KODJOE License Number: 18367

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: N/A	☐	☒ Sterile Compounding
		☐	☒ Non Sterile Compounding
All boxes must be checked		☐	☒ Mail Service Sterile Compounding
For the application to be complete		☐	☒ Other Services: N/A

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

EMMANUEL KODJOE
Print Name of Authorized Person

10/03/2019
Date

Board Use Only Date Processed:_____ Amount: 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: PINNACLE ABSOLUTE CARE, LLC

Mailing Address: 840 CHAPARRAL DR

City: MESQUITE State: NV Zip: 89027

Telephone: 702-241-9653 Fax: 702-346-1718

Contact Person: EMMANUEL KODJOE

For any corporation non publicly traded, disclose the following:

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

a) N/A
Name 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. N/A

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

List any physician shareholders and percentage of ownership.

Name: N/A %: N/A

Name: N/A %: N/A

Hours of Operation for the pharmacy:

Monday thru Friday 9:00 am 6:00 pm Saturday CLOSED am ____ pm

Sunday CLOSED am ____ pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20171449639

APPLICATION FOR NEVADA PHARMACY LICENSE

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

Owner's Name: EMMANUEL KODJOE

Business Name: ATLANTIC PHARMACY

Current Business Address: 2815 W. LAKE MEAD BLVD, SUITE 109

City: NORTH LAS VEGAS State: NV Zip Code: 89032

Telephone: 702-241-9653 Fax: 702-346-1718

List any physician shareholders and percentage of ownership.

Name: N/A %: N/A

Name: N/A %: N/A

Name: N/A %: N/A

Name: N/A %: N/A

Hours of Operation for the pharmacy:

Monday thru Friday 9:00 am 6:00 pm Saturday CLOSED am _____ pm

Sunday CLOSED am _____ pm 24 Hours N/A

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: NV20171449639

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

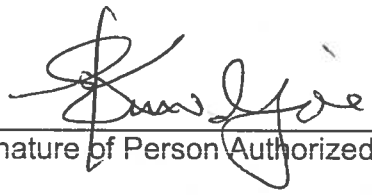
I, EMMANUEL KODJOE

Responsible Person of ATLANTIC 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

Emmanuel Kodjoe

Print Name of Authorized Person

10/03/2019

Date

Managing Pharmacist

Pharmacist Name: EMMANUEL KODJOE License #: 18367

Pharmacy Name: ATLANTIC 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: N/A Date: N/A Case #: N/A

And/or Criminal Action: State: N/A Date: N/A Case #: N/A

County N/A Court: N/A

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 10/03/2019

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 10/02/2019

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Nevada Pharmacy License
Nature of License

PINNACLE ABSOLUTE CARE LLC, 840 CHAPARRAL DR, MESQUITE, NV 89027
Name and Address of Establishment for Which License Is Requested

Doing Business As: Atlantic Pharmacy, 2815 W. Lake Mead Blvd, Suite 109, North Las Vegas, NV 89032
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Kodjoe	Emmanuel	
Last Name	First Name	Middle Name

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

Chaparral Dr	Mesquite	NV/ 89027
Present Residence Address-Street or RFD	City	State/Zip

2815 W. Lake Mead Blvd, Suite 109	Dates N/A (yet to start)	North Las Vegas	NV/ 89032
Present Business Address		City	State/Zip

Pharmacist	Dates N/A (yet to start)	NV/89032
Occupation		Phone: Residence N/A
		Business N/A

Accra, Ghana	
Date of Birth	Place of Birth (City, County, State)

46		M
Age	Social Security Number	Sex

Brown	Black	Black	177 lbs	N/A	5'07"
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 USCIS #: Permanent Resident

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 EK

MARITAL INFORMATION-Continued

A. **Current Marriage** 12/04/1999 (Date) Accra, Ghana (City, County and State)

Spouse's full name (Maiden) Gladys Ampong S.S. No

Date of Birth Place of Birth Takoradi, Ghana

Resident address Chaparral Dr (Street) Mesquite (City) NV (State) 89027 (Zip)

Telephone: Residence N/A Business 702-345-3312

Spouse's employer Aumbria Health Occupation Physician

Address of employer 350 Falcon Ridge Pkwy, Suite 102 (Street) Mesquite (City) NV (State) 89027 (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	N/A	N/A	N/A	N/A

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

Name	Street	City	State	Zip	Telephone
N/A	N/A	N/A	N/A	N/A	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
Cameron Kodjoe		Accra, Ghana	Chaparral Dr, Mesquite, NV 89027

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 EK

FAMILY INFORMATION-Continued

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

Name N/A

Address N/A

Contact person N/A

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Francis Kodjoe		Deceased	N/A
Mother	Sabina Offah		Deceased	N/A
Father-in-Law	Moses Ampong		P.O.Box , Accra, Ghana	Businessman (Ret.)
Mother-in-Law	Mercy Cobbinah		P.O.Box , Dadieso, Ghana	Teacher (Ret.)

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
	Michael Kodjoe		Donald Rd, Croydon, UK	Chartered Accountant
Spouse	Selasie Kodjoe		Donald Rd, Croydon, UK	Teacher
	Clara Kodjoe		Deceased	N/A
Spouse	N/A			
	Harriet Kodjoe		P.O.Box Saltpond, Ghana	Social Worker
Spouse	N/A			
	Benjamin Kodjoe		P.O.Box Saltpond, Ghana	Businessman
Spouse	N/A			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Ideal Preparatory School	Takoradi, Ghana	1980 - 1986	Yes ☒ No ☐
High School	St. Augustine's College	Cape-Coast, Ghana	1986 - 1993	Yes ☒ No ☐
College University	University of Ghana, Legon	Accra, Ghana	1994 - 1998	Yes ☒ No ☐
Other	Eastern New Mexico University	Portales, NM	2004 - 2006	Yes ☒ No ☐

Type of degree obtained, if any PharmD

College or university where obtained Roseman Univeristy of Health Sciences, Henderson, NV 2009 - 2012

Applicant's initial EK

5 MILITARY INFORMATION:

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

Branch N/A Date of entry-active service N/A

Date of separation N/A Type of discharge N/A

Rating at separation N/A Serial number N/A

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

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

County N/A State N/A Date registered N/A

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

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

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

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

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

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

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒
If yes, when? 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	N/A	N/A

Applicant's initial EK

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	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

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
03/2015 - Present	Chaparral Dr	Mesquite	NV
08/2014 - 03/2015	4010 Watford Way	Fayetteville	NC
08/2012 - 08/2014	2811 Powder Ridge Dr	Bismarck	ND
08/2009 - 08/2012	840 Chaparral Dr	Mesquite	NV
09/2007 - 08/2009	22900 Nicholas Ave	Euclid	OH
12/2006 - 01/2007	24350 Garden Dr, Apt 1405	Euclid	OH
01/2004 - 12/2006	ENMU 2846 1500 S. Ave K	Portales	NM
01/2002 - 01/2004	4 South Norwood	Croydon	UK
06/1980 - 01/2002	KB 455 Korle-Bu	Accra	Ghana

Applicant's initial EK

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.

01/2018 Owner/Managing Pharmacist Mesquite Pharmacy 114 N. Sandhill Blvd, Ste B Pharmacy Closed/Sold

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
02/2017	Walmart Pharmacy, 6570 E. Lakemead Blvd, Las Vegas,NV	Laid off due to restructuring
Title	**Description of Duties**	**Name of Supervisor**
Floater Pharmacist	Verifying and dispensing medications,patient counseling	Johnny Lopez

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
04/2015	Walmart Pharmacy, 1120 W. Pioneer Blvd, Mesquite,NV	Stepped down as Manager
Title	**Description of Duties**	**Name of Supervisor**
Pharmacy Manager	Managing daily operations of pharmacy/dispensing	Sean Rammell

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
12/2014	Walmart Pharmacy, 7701 S. Raeford Rd, Fayetteville,NC	Relocation to Nevada
Title	**Description of Duties**	**Name of Supervisor**
Staff Pharmacist	Verifying and dispensing medications,patient counseling	Kim Monroe

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
10/2014	CVS Pharmacy, 4923 Raeford Rd, Fayetteville,NC	Changed jobs for better conditions
Title	**Description of Duties**	**Name of Supervisor**
Staff Pharmacist	Verifying and dispensing medications,patient counseling	Gloria Johnson

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
06/2014	Elbowoods Memorial Health Center, 1058 College Dr, Newtown,ND	Relocation to N. Carolina
Title	**Description of Duties**	**Name of Supervisor**
Relief Pharmacist	Verifying and dispensing medications,patient counseling	Adel Moe

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
12/2013-05/2014	Unemployed	N/A
Title	**Description of Duties**	**Name of Supervisor**
N/A	N/A	N/A

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
11/2012	Sanford Health, 300N. 7th St,Bismarck,ND	Left for better paying job
Title	**Description of Duties**	**Name of Supervisor**
In-patient Staff Pharmacist	Verifying and dispensing medications,patient counseling	Gregory Fritz

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
08/2009-11/2012	Went back to school (Roseman University)	N/A
Title	**Description of Duties**	**Name of Supervisor**
Student	N/A	N/A

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

Applicant's initial EK

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 Alexander Odame	Home	Rock Island Rd, Apt 201, VA 22150				31
Employer N/A	Business	N/A				
Name Dr. Edward Ofori	Home	N/A				
Employer Self employed	Business	Mesquite Women's Clinic				
Name Dr. prince Ofosu-Mensah	Home	1 Ave E, Langhorne PA, 19047				
Employer N/A	Business	N/A				
Name Derek Boateng	Home	N/A				
Employer Self Employed	Business	Health Matters Pharmacy				
Name Judy Boateng	Home	N/A				
Employer N/A	Business	N/A				

10. Do you have any safe deposit box or other such depository, access to any depository or do you use any other person s depository? Yes ☐ No ☒
If yes, complete the following:

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A	N/A	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
Accountant	Pilot	Sports promoter	Trainer or manager	Educator

Yes ☐ No ☒
If yes, state type, where and years held
N/A

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

Applicant s initial EK

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 ☒

N/A

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

N/A

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

N/A

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

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 ☒

N/A

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 ☒

N/A

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 ☒

N/A

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 ☒

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

Date of photograph 10/04/2019

Applicant's initial EK

STATE OF Nevada

ss.

COUNTY OF Clark

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

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

Original Signature of Applicant

Subscribed and Sworn to before me this 4th day of October, 2019

Notary Public

ANTHONY D. MATOS
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 12-08-2021
Certificate No: 14-12849-1

(seal)

Applicant's initial EK

ADDITIONAL INFORMATION

N/A
N/A
N/A
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N/A

Applicant's initial EK

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

Date 10/03/2019

GENERAL INSTRUCTIONS

Type an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, continue on page 10 or use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner. By placing his initials on each page, the applicant is attesting to the accuracy and completeness of the information contained on that page.

All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for Nevada Pharmacy License
Nature of Pharmacy or Wholesaler

Pinnacle Absolute Care LLC, 840 Chaparral Dr, Mesquite, NV, 89027
Name and Address of Business for Which Designated Representative Is Requested

Doing Business As: Atlantic Pharmacy, 2815 W. Lake Mead Blvd, Suite 109, North Las Vegas, 89032
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Kodjoe	Emmanuel	

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

Present Residence Address-Street or RFD	City	State/Zip
Chaparral Dr	Mesquite	NV/ 89027

Present Business Address	Dates	City	State/Zip
2815 W. Lake Mead Blvd, Suite 109	N/A (yet to start)	North Las Vegas	NV/ 89032

Present Position with the Pharmacy or Wholesaler	Dates		Phone:
Managing Pharmacist	N/A (yet to start)	North Las Vegas NV/ 89032	Residence N/A
			Business 702-241-9653

Date of Birth	Place of Birth (City, County, State)
46	Accra, Ghana

Age	Social Security Number	Sex
		M

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Brown	Black	Black/Dark	177 lbs	N/A	5'07"

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

Are you a citizen of the United States? Yes ☐ No ☒ If alien, registration No USCIS # Permanent Resident

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 EK

MARITAL INFORMATION-Continued

A. **Current Marriage** 12-04-1999 (Date) Accra, Ghana (City, County and State)

Spouse's full name (Maiden) Gladys Ampong S.S. No

Date of Birth Place of Birth Takoradi, Ghana

Resident address Chaparral Dr (Street) Mesquite (City) NV (State) 89027 (Zip)

Telephone: Residence N/A Business 702-345-3312

Spouse's employer Aumbria Health Occupation Physician

Address of employer 350 Falcon Ridge Pkwy, Suite 102 (Street) Mesquite (City) NV (State) 89027 (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	N/A	N/A	N/A	N/A

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

Name	Street	City	State	Zip	Telephone
N/A	N/A	N/A	N/A	N/A	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
Cameron Kodjoe		Accra, Ghana	Chaparral Dr, Mesquite, NV 89027

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 EK

FAMILY INFORMATION-Continued

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

Name N/A

Address N/A

Contact person N/A

C. Parents:

List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, parents-in-law or legal guardian. If retired or deceased, list last address and occupation.

	Name (Maiden)	Birth Date	Address	Occupation
Father	Francis Kodjoe		Deceased	N/A
Mother	Sabina Offah		Deceased	N/A
Father-in-Law	Moses Ampong		P.O.Box KB Korle-Bu, Ghana	Businessman
Mother-in-Law	Mercy Cobbinah		P.O.Box , Dadieso, Ghana	Teacher (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
	Michael Kodjoe		Donald Rd, Croydon, UK CRO 3EQ	Charted Accountant
Spouse	Selasi Kodjoe		Donald Rd, Croydon, UK CRO 3EQ	Stay at home mom
	Clara Kodjoe		Deceased	N/A
Spouse	N/A	N/A	N/A	N/A
	Harriet Kodjoe		P.O.Box Saltpond, Ghana	Social Worker
Spouse	N/A	N/A	N/A	N/A
	Benjamin Kodjoe		P.O.Box Saltpond, Ghana	Businessman
Spouse	N/A	N/A	N/A	N/A

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Ideal Prep. School	Takoradi, Ghana	1980-1986	Yes ☒ No ☐
High School	St. Augustine's College	Cape-Coast, Ghana	1986-1993	Yes ☒ No ☐
College University	University of Ghana Eastern New Mexico University	Accra, Ghana Portales, NM	1994-1998 2004-2006	Yes ☒ No ☐
Other	Roseman University of Health Sciences	Henderson, NV	2009-2012	Yes ☒ No ☐

Type of degree obtained, if any BS (University of Ghana), MBA (International University), MS (Eastern New Mexico Univ)

College or university where obtained PharmD (Roseman University of Health Sciences)

Applicant s initial EK

5 MILITARY INFORMATION:

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

Branch N/A Date of entry-active service N/A

Date of separation N/A Type of discharge N/A

Rating at separation N/A Serial number N/A

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

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

County N/A State N/A Date registered N/A

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

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

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

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

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

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

E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes ☐ No ☒

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☒
If yes, when? 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	N/A	N/A

Applicant's initial EK

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	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

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
03/2015 - Present	840 Chaparral Dr	Mesquite	NV
08/2014 - 03/2015	4010 Watford Way	Fayetteville	NC
08/2012 - 08/2014	2811 Powder Ridge Dr	Bismarck	ND
08/2009 - 08/2012	840 Chaparral Dr	Mesquite	NV
01/2007 - 08/2009	22900 Nicholas Ave	Euclid	OH
12/2006 - 01/2007	24350 Garden Dr	Euclid	OH
01/2004 - 12/2006	ENMU 2846 1500 S. Ave K	Portales	NM
01/2002 - 01/2004	#4 South Norwood Hill	Croydon	UK
06/1980 - 01/2002	KB 455 Korle-Bu	Accra	Ghana

Applicant s initial EK

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
01/2018	Mesquite Pharmacy, 114 N. Sandhill Blvd, Suite B & C	3,360 Hours
Title	**Description of Duties**	**Name of Supervisor**
Owner/Managing Pharmacist	Managing daily operations of the pharmacy plus dispensing duties.	

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
02/2017	Walmart Pharmacy, 6570 E. Lakemead Blvd, Las Vegas,NV	800 Hours
Title	**Description of Duties**	**Name of Supervisor**
Floater Pharmacist	Verifying and dispensing prescriptions, patient counseling	Johnny Lopez

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
04/2015	Walmart Pharmacy, 1120 W. Pioneer Blvd, Mesquite, NV	3,360 Hours
Title	**Description of Duties**	**Name of Supervisor**
Pharmacy Manager	Managing daily operation of the pharmacy and dispensing duties as well	Sean Rammell

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
12/2014	Walmart Pharmacy, 7701 S. Raeford Rd , Fayetteville, NC	640 Hours
Title	**Description of Duties**	**Name of Supervisor**
Staff Pharmacist	Verifying and dispensing prescriptions, patient counseling	Kim Monroe

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
10/2014	CVS Pharmacy, 4923 Raeford Rd, Fayetteville, NC	320 Hours
Title	**Description of Duties**	**Name of Supervisor**
Staff Pharmacist	Verifying and dispensing prescriptions, patient counseling	Gloria Johnson

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
06/2014	Elbowoods Memorial Health Center, 1058 College Dr,Newtown,ND	480 Hours
Title	**Description of Duties**	**Name of Supervisor**
Relief Pharmacist	Verifying and dispensing prescriptions, patient counseling	Adel Moe

Month and Year	Name/Mailing Address of Employer/Business	Number of Employed Hours
11/2012	Sanford Health Pharmacy, 300 N. 7th St, Bismarck,ND	2,080 Hours
Title	**Description of Duties**	**Name of Supervisor**
In-Patient Pharmacist	Verifying and dispensing prescriptions, patient counseling	Gregory Fritz

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

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

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

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

Applicant's initial EK

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 Alexander Odame	Home	4 Rock Island Rd, Apt 201,Springfield,VA 22150,				31
Employer N/A	Business	N/A				
Name Dr. Edward Ofori	Home	N/A				8
Employer Mesquite Women's Clinic	Business	Bertha Howe Ave, Mesquite, NV 89027				
NameDr. Prince Ofosu-Mensah	Home	Ave E, Langhorne, PA 19047				20
Employer N/A	Business	N/A				
Name Derek Boateng	Home	N/A				20
Employer Walgreens Pharmacy	Business	N/A				
Name Judy Boateng	Home	N/A				20
Employer N/A	Business	N/A				

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

N/A

N/A

N/A

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.

N/A

N/A

N/A

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 ☒

N/A

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

N/A

N/A

Applicant's initial EK

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 ☒

N/A

N/A

N/A

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 ☐

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

Date of photograph 10/04/2019

Applicant's initial EK

STATE OF Nevada

ss.

COUNTY OF Clark

I, Emmanuel Kodjoe, 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 4th day of October, 2019

Notary Public

ANTHONY D. MATOS
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 12-08-2021
Certificate No: 14-12849-1

(seal)

Applicant's initial EK

ADDITIONAL INFORMATION

N/A

Applicant's initial EK

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, Barbara K. Cegavske, the duly qualified and elected Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporations sole, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada standing Revised Statutes which are either presently in a status of good standing or were in good for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **PINNACLE ABSOLUTE CARE L.L.C.**, as a DOMESTIC LIMITED-LIABILITY COMPANY (86) duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since 07/17/2017, and is in good standing in this state.

I further certify that the above DOMESTIC LIMITED-LIABILITY COMPANY (86) has its formation document and no amendments on file in this office as of the date of this certificate.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on 10/04/2019.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Certificate Number: B20191004271977
You may verify this certificate online at http://www.nvsos.gov

8B

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~~ **IB01550** **(Seller's)**
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: **PAM Specialty Hospital of Las Vegas LLC, d/b/a PAM Specialty Hospital of Las Vegas**

Physical Address: **2500 N. Tenaya Way**

City: **Las Vegas, NV** State: Zip Code: **89128** Telephone: **(702) 562-2021**

Fax: **(702) 562-2074** Toll Free Number: **N/A**

E-mail: **lane.cheramie@cardinalhealth.com**

Website: **www.postacutemedical.com**

Managing Pharmacist: **Lane Cheramie** License Number: **16613**

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No		Yes/No	
☐	☐ Retail	☐	☒ Off-site Cognitive Services
☒	☐ Hospital (# beds **70**)	☒	☐ 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.

X _____

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

Anthony Misitano

Print Name of Authorized Person

10/11/2019

Date

Board Use Only	Date Processed:	Amount: $ 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

Limited Liability Company

OWNERSHIP IS A ~~PARTNERSHIP~~. All persons listed as a partner must accurately complete a personal history record form.

Type of Partnership: General_____ Limited _____ **X Limited Liability Company**

List names of 4 largest partners and percentage of ownership:

Name: **Brittany Misitano, Vice President and Secretary** %: **67.5%**

Name: **Anthony Misitano, President** %:

Name: **Karick Stober, Vice President and Treasurer** %:

Name: %:

Limited Liability Company

~~Partnership~~ Name: **PAM Specialty Hospital of Las Vegas LLC**

Mailing Address: **1828 Good Hope Road, Suite 102**

City, State Zip Code: **Enola, PA 17025**

Telephone Number: **717-731-9660** Fax Number: **717-695-0318**

Contact Person: **Erin R. Bosley, Esq.**

List any physician shareholders and percentage of ownership.

Name: **N/A** %:

Name: %:

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday **7:30** am **7:00** pm Saturday **7:30** am **5:00** pm

Sunday **7:30** am **5:00** pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: **NV20191582190**

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

I, Anthony Misitano

Responsible Person of **PAM Specialty Hospital of Las Vegas 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.

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

Anthony Misitano
Print Name of Authorized Person

10/11/2019
Date

Managing Pharmacist

Pharmacist Name: **Lane Cheramie** License #: 16613

Pharmacy Name: **PAM Specialty Hospital of Las Vegas LLC**

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

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

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

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

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

Board Administrative Action: State: _____ 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.

Laure Cheramie
Signature

10/10/2019
Date

LATSHA DAVIS & MARSHALL

ATTORNEYS AT LAW

PLEASE REPLY TO: Mechanicsburg
WRITER'S E-MAIL: mfournier@ldylaw.com

October 17, 2019

Via Federal Express – Standard Overnight Delivery ***#7767 4424 5297***

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

Re: CHANGE OF OWNERSHIP – HOSPITAL PHARMACY
Seller: New LifeCare Hospitals at Tenaya, LLC, d/b/a Complex Care Hospital at Tenaya
Buyer: PAM Specialty Hospital of Las Vegas LLC, d/b/a PAM Specialty Hospital of Las Vegas
Pharmacy License No.: IB01550
Our File No.: 391-19

Dear Sir/Madam:

We are writing to advise the Nevada State Board of Pharmacy, of a change of ownership of the long-term care hospital and its institutional pharmacy known as New LifeCare Hospitals at Tenaya, LLC, d/b/a Complex Care Hospital at Tenaya, located at 2500 North Tenaya Way, Las Vegas, NV 89128 (the "Facility"). A detailed description of this change of ownership is set forth below.

Hospital Acquisition LLC and certain of its affiliates ("LifeCare"), including New LifeCare Hospitals at Tenaya, LLC, filed a Chapter 11 Bankruptcy Petition in the United States Bankruptcy Court for the District of Delaware. In connection with the Bankruptcy Case, LifeCare entered into an Asset Purchase Agreement ("APA") to sell the assets of the Facility, which was approved by the Bankruptcy Court.

Effective September 30, 2019, New LifeCare Hospitals at Tenaya, LLC transferred the operational responsibilities for the Facility to PAM Specialty Hospital of Las Vegas LLC, which became the new operator/provider, doing business as "PAM Specialty Hospital of Las Vegas."

To effectuate this change of ownership, enclosed please find a completed Application for Nevada Pharmacy License, along with a check in the amount of $500.00 made payable to the Nevada State Board of Pharmacy.

Please contact our office immediately if you have any questions or require additional information.

Sincerely,

Michelle L. Fournier
Paralegal

Enclosures

cc: Erin R. Bosley, Esq. (w/ enc.)

8C

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.

1864

☐ New Pharmacy or ☒ Ownership Change (Provide current license number if making changes: ~~PH~~ **IB01~~850~~ (Seller's)**
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: **PAM Specialty Hospital of Reno LLC, d/b/a PAM Specialty Hospital of Sparks**

Physical Address: **2375 East Prater Way, 7th Floor**

City: **Sparks, NV** State: Zip Code: **89434** Telephone: **(775) 355-5600**

Fax: **(702) 562-2074** Toll Free Number: **N/A**

E-mail:

Website: **www.postacutemedical.com**

Managing Pharmacist: **Paul Oesterman** License Number: **10109**

TYPE OF PHARMACY AND SERVICES PROVIDED

Yes/No	TYPE OF PHARMACY	Yes/No	SERVICES PROVIDED
☐	☐ Retail	☐	☒ Off-site Cognitive Services
☒	☐ Hospital (# beds **21**)	☒	☐ 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.

X _____

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

Anthony Misitano

Print Name of Authorized Person

10/11/2019

Date

Board Use Only	Date Processed:_____	Amount: $ 500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

Limited Liability Company

OWNERSHIP IS A ~~PARTNERSHIP~~. All persons listed as a partner must accurately complete a personal history record form.

Type of Partnership: General_____ Limited _____ **X Limited Liability Company**

List names of 4 largest partners and percentage of ownership:

Name: **Brittany Misitano, Vice President and Secretary** %: **67.5%**

Name: **Anthony Misitano, President** %:

Name: **Karick Stober, Vice President and Treasurer** %:

Name: %:

Limited Liability Company

~~Partnership~~ Name: **PAM Specialty Hospital of Reno LLC**

Mailing Address: **1828 Good Hope Road, Suite 102**

City, State Zip Code: **Enola, PA 17025**

Telephone Number: **717-731-9660** Fax Number: **717-695-0318**

Contact Person: **Erin R. Bosley, Esq.**

List any physician shareholders and percentage of ownership.

Name: **N/A** %:

Name: %:

Name: %:

Hours of Operation for the pharmacy:

Monday thru Friday **8:00** am **4:30** pm Saturday **CLOSED** am _____pm

Sunday **CLOSED** am _____pm 24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: **NV20191582184**

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

I, Anthony Misitano

Responsible Person of **PAM Specialty Hospital of Reno 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.

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

Anthony Misitano
Print Name of Authorized Person

10/11/2019
Date

Managing Pharmacist

Pharmacist Name: **Paul Oesterman** License #: **10109**

Pharmacy Name: **PAM Specialty Hospital of Reno LLC**

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

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

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

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

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

Board Administrative Action: State: _____ Date: _____ Case #: _____

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

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

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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 10/14/19

LATSHA DAVIS & MARSHALL

ATTORNEYS AT LAW

PLEASE REPLY TO: Mechanicsburg
WRITER'S E-MAIL: mfournier@ldylaw.com

October 17, 2019

Via Federal Express – Standard Overnight Delivery ***#7767 4424 5297***

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

Re: CHANGE OF OWNERSHIP – HOSPITAL PHARMACY
Seller: New LifeCare Hospitals at Northern Nevada, LLC, d/b/a Tahoe Pacific Hospitals - North
Buyer: PAM Specialty Hospital of Reno LLC, d/b/a PAM Specialty Hospital of Sparks
Pharmacy License No.: IB01864
Our File No.: 391-19

Dear Sir/Madam:

We are writing to advise the Nevada State Board of Pharmacy, of a change of ownership of the long-term care hospital and its institutional pharmacy known as New LifeCare Hospitals at Northern Nevada, LLC, d/b/a Tahoe Pacific Hospitals - North, located at 2375 East Prater Way, 7th Floor, Sparks, NV 89434 (the "Facility"). A detailed description of this change of ownership is set forth below.

Hospital Acquisition LLC and certain of its affiliates ("LifeCare"), including New LifeCare Hospitals at Northern Nevada, LLC, filed a Chapter 11 Bankruptcy Petition in the United States Bankruptcy Court for the District of Delaware. In connection with the Bankruptcy Case, LifeCare entered into an Asset Purchase Agreement ("APA") to sell the assets of the Facility, which was approved by the Bankruptcy Court.

Effective September 30, 2019, New LifeCare Hospitals at Nevada, LLC transferred the operational responsibilities for the Facility to PAM Specialty Hospital of Reno LLC, which became the new operator/provider, doing business as "PAM Specialty Hospital of Sparks."

To effectuate this change of ownership, enclosed please find a completed Application for Nevada Pharmacy License, along with a check in the amount of $500.00 made payable to the Nevada State Board of Pharmacy.

Please contact our office immediately if you have any questions or require additional information.

Sincerely,

Michelle L. Fournier
Paralegal

Enclosures

cc: Erin R. Bosley, Esq. (w/ enc.)