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NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$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.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: MP or MW _____)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input checked="" type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: All time Health care

Physical Address: 4660 S. Eastern Ave Ste # 100 LV NV 89119
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 4660 S. Eastern Ave Ste # 100

City: LV State: NV Zip Code: 89119

Telephone: 702-480-5617 Fax: _____

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

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5PM Tue: 9am to 5PM Wed: 9am to 5PM Thu: 9am to 5PM

Fri: 9am to 5PM Sat: 9am to 5PM Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Angelica Gutierrez

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

- | | |
|---|--|
| <input type="checkbox"/> Medical Gases** | <input checked="" type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input checked="" type="checkbox"/> Diabetic Supplies | Other: <u>Incontinence & disposable supplies</u> |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: _____ Telephone: _____

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

<u>Medicare</u>	<u>in process</u>	_____
<u>Medicaid</u>	<u>in process</u>	_____
_____	_____	_____

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes No
- 2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes No
- 3) Are any of the owners health professionals? If yes, please check the box and list name.

<input type="checkbox"/> Practitioner	Name: _____
<input type="checkbox"/> Advanced Practitioner of Nursing	Name: _____
<input type="checkbox"/> Physician's Assistant	Name: _____
<input type="checkbox"/> Physical Therapist	Name: _____
<input type="checkbox"/> Occupational Therapist	Name: _____
<input type="checkbox"/> Registered Nurse	Name: _____
<input type="checkbox"/> Respiratory Therapist	Name: _____

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

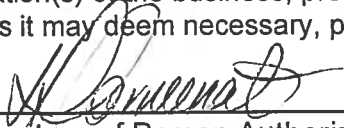
Within the last five (5) years:

- 1) Has the corporation, any owner, 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 MDEG provider or wholesaler may be grounds for the revocation of this permit.

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


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

Dailin Carmenate Avias 3/27/19
Print Name of Authorized Person Date

Board Use Only	Received: _____	Amount: <u>500.00</u>
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APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Dailin Carmenate Rivas

Business Name: all time Healthcare

Current Business Address: 4060 S Eastern Ave ste # 100

City: W State: NV Zip: 89119

Telephone: 702-480-5617 Fax: _____

SOLE OWNER**Include with the application for a sole owner**

Complete personal history record Must be original signature(s), no copies or stamps. Download the form from the website. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

SECRETARY OF STATE



NEVADA STATE BUSINESS LICENSE

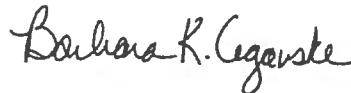
ALL TIME HEALTH CARE LLC
Nevada Business Identification # NV20191240010

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 27, 2019



Barbara K. Cegavske
Secretary of State



You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law cannot be waived.

SECRETARY OF STATE



LIMITED LIABILITY COMPANY CHARTER

I, Barbara K. Cegavske, the Nevada Secretary of State, do hereby certify that **ALL TIME HEALTH CARE LLC** did on March 27, 2019, file in this office the Articles of Organization for a Limited Liability Company, that said Articles of Organization is now on file and of record in the office of the Nevada Secretary of State, and further, that said Articles contain all the provisions required by the laws governing Limited Liability Companies in the State of Nevada.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on March 27, 2019.

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

Certified By: Electronic Filing
Certificate Number: C20190327-1751

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 3/22/19

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, 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.

All applicants are advised that this application to be a MDEG administrator 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 Durable Medical Equipment

Nature of MDEG

Alltime Health care 4000 S. Eastern ave ste 100 W NV 89119
Name and Address of Business for Which MDEG Administrator Is Requested

.....
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Gutierrez Last Name Angelica First Name _____ Middle Name _____

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

Spring Rain Rd Present Residence Address-Street or RFD Las Vegas City NV 89142 State/Zip

4660 S. Eastern Ave. Suite 100 Present Business Address Las Vegas City NV 89119 State/Zip

Administrator Present Position with the MDEG 4/1/19 - Present Dates

Phone: _____ Fax: _____

Email address: All time health care 19 @ gmail . com

Date of Birth Las Vegas, USA, NV Place of Birth (City, County, State)

22 Age _____ _____ Social Security Number _____ F Sex

Brown Color of Eyes Brown Color of Hair 120 Weight _____ 5'0 Height

Scars, tattoos or distinguishing marks and/or characteristics _____

Are you a citizen of the United States? Yes No

If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

Jan 2017-2019 Touro Health Center 874 American Pacific Dr NV. (3840) 89104
Month and Year Name/ Address of Employer/Business No of Employed Hours

Front office receptionist Tina Galendo
Title Description of Duties Name of Supervisor

Jan 2017 3115 S. Eastern Ave. LV NV 89169
September 2015- Cima Medical Center 3840
Month and Year Name/ Address of Employer/Business No of Employed Hours

Front office receptionist Patricia Webb
Title Description of Duties Name of Supervisor

March 2013 - Sep. 2015 3111 S. Maryland Pkwy 89169 LV NV
Month and Year Name/ Address of Employer/Business No of Employed Hours

Quick Care Las Vegas 3840
Front office receptionist & Billing Mario Tarquillino
Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

I have I have not been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

- 1. I have I have not been charged, arrested or convicted of a felony or misdemeanor.
- 2. I have I have not been the subject of an administrative action whether completed or pending.
- 3. I have I have not had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information and provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes No

5 .Will you be employed fulltime with the MDEG? Yes No

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes No

If you answer No to questions 4, 5 or 6 please provide a written letter of explanation.

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Date c



3/11/2019

I, Angelica Gutierrez

, 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 MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

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 MDEG in the State of Nevada.



Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 3/27/19

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 Durable Medical Equipment
Alltime Healthcare 4660 S. Eastern Ave Ste 60 W NV 89119
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name Carmenate Pivas First Name Wailin Middle Name

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

n/a Present Residence Address-Street or RFD Rosario Cir Las Vegas, NV 89121 -1
City Las Vegas State/Zip NV 89121

2840 E. Flamingo Rd Present Business Address Las Vegas City NV 89121 State/Zip

Owner Occupation Dates

Phone: Residence Business

Date of Birth / 33 Place of Birth (City, County, State) Las Tunas, Cuba

Age 33 Social Security Number Sex Female

Color of Eyes Black Color of Hair Brown Complexion 172 Weight 5.3 Build 5.3 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 ~~11/17/2006~~ n/a

If naturalized, certificate No Date 11/17/2006

Place Las Vegas, Nevada (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single Married Separated Divorced Widowed Engaged

Applicant's initial DCR

MARITAL INFORMATION-Continued

A. **Current Marriage** 2/20/2005 Las Vegas, NV USA
Date City, County and State
 Spouse's full name (Maiden) OHAN Deivys Gutierrez S.S. No. -
 Date of Birth _____ Place of Birth Cardenas, Matanzas Cuba
 Resident address Rosario Cir Las Vegas NV 89121
Street City State Zip
 Telephone: Residence _____ Business _____
 Spouse's employer Self Employ Occupation Driver
 Address of employer Amazon Delivery Las Vegas NV
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
<u>N/A</u>				

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

Name	Street	City	State	Zip	Telephone

3. **FAMILY INFORMATION:**

A. **Children and Dependents:**

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
<u>Milith Gutierrez</u>	' ' -	<u>USA</u>	<u>Rosario Cir LV NV</u>
<u>Keilyn Gutierrez</u>	' ' ,	<u>USA</u>	<u>Rosario Cir LV NV</u>
<u>Angelica Gutierrez</u>	' ' ,	<u>USA</u>	<u>Spring Rain Rd LV NV</u>

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 DCR

FAMILY INFORMATION-Continued

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

Name
Address
Contact person

C. Parents:

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

Name (Maiden)	Birth Date	Address	Occupation
Father Norberto Carmenate Sanchez	- 6/1/11		Deceased.
Mother Margarita Rivas Aceña	1/1/11	Palora Ave LV NV 89111	
Father-in-Law Enrique Ramirez Pelegrin	1/1/11	Palora Ave LV NV 89169	
Mother-in-Law			

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
Deiker Carmenate Rivas		Palora Ave LV NV	Packer.
Spouse Yailin Torres Guerra		Same Address	Unemploy.
Spouse			
Spouse			
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	El Dorado Highschool	Las Vegas, NV	1999/2003	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
High School	Valley Highschool	Las Vegas NV		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
College University	Las Vegas College	Las Vegas, USA	2003/2005	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other				Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any Bookkeeping

College or university where obtained Las Vegas college.

Applicant's initial DCR

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.....State.....Date registered.....

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

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

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

- B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes No If yes, furnish details on page 10.
- C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes No
- D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes No
- E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes No
- F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes No
If yes, when?.....city, county and state.....
- G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes No
If yes when?.....city, county and state.....
- H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes No
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date

Applicant's initial.....Page 4

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

- 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

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
12/2013-Present	Rosalie cir	Las Vegas, Nevada	USA
12/2012/12/2013-	? Aracatuba Ave	Las Vegas, Nevada	USA
2011 -2013	2900 Olive St Apt 11	Las Vegas NV	USA
2009-2011	500 S. Maryland Prwy	Las Vegas	
2005-2009	1924 Golden Arrow Dr	LV NV	89169
2000 -2005	4801 Lakestream Ave	LV NV	89

Applicant's initial DCR
 Page 5

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2015	Express Tax Services 2840 E. Flamingo Rd	n/A Owner.

Title	Description of Duties	Name of Supervisor
Owner	tax preparer -	Self.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
04/2015 to 01/2019	At Your Services Home Care 1785 E. Sahara	NO MORE CLIENT

Title	Description of Duties	Name of Supervisor
Personal care	visit client help w/daily basic.	Fernando.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2014/04-17	AM/PM Home care 820 Rancho Ln LV NV 89106	Better Salary.

Title	Description of Duties	Name of Supervisor
Personal care	visit clients help w/daily care basic.	---

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
06/2005/12/2013	The Venetian Hotel 3355 S. LV Blvd.	Looking for a better business

Title	Description of Duties	Name of Supervisor
Attendant	Restock mini bar in Hotel Rooms.	Sebastian.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/18-Present	Allstate Ins. 3265 E. Tropicana Ave	open still employed.

Title	Description of Duties	Name of Supervisor
Sales	sale ins. Policies.	Yolanda Sitto.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving

Title	Description of Duties	Name of Supervisor

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving

Title	Description of Duties	Name of Supervisor

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving

Title	Description of Duties	Name of Supervisor

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

Applicant's initial DCR Page 6

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
Wynn Hotel Name: Leandro Ramirez	Home	Palmer	NV	89169	:	10+
Employer: Wynn Hotel	Business	3131 S. Las Vegas Blvd			702-770-7000	10+
Name: Laura Senda	Home	Bel Port Dr			89110	5 1/2+
Employer: All state Ins	Business	3265 E. Tropicana Ave E-1 LV NV				
Name: Yolanda Cotto	Home	Montagna Dr			LV NV 89139	6 years
Employer: All state Ins	Business	3265 E. Tropicana Ave E.1 LV NV				702 908-7450
Name: Yusimi Betarte	Home	E. Imperial Ave			LV NV 89104	10 years
Employer: Amazon Delivery	Business					
Name: Vosbol James	Home	E. Imperial Ave.				
Employer: Self employed	Business	Self employed				6 years

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

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

Sales Insurance, Las Vegas, NV 1/24/2017

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.

Solepropor - Express tax Services - Las Vegas, NV
Tax Preparation preparer - 2015 - Present.
2840 E. Flamingo Rd Suite Las Vegas, NV 89121

Applicant's initial

DCR

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

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

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

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

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

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

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

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

A1



Date of photograph 3/11/19

Applicant's initial DCR

STATE OF Nevada

SS.

COUNTY OF Clark

I, Dailin Carmenate Rivas, 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 or fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

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

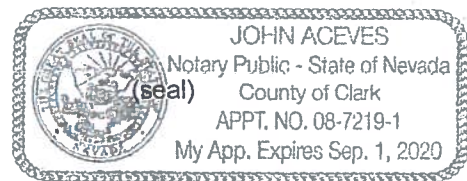
State of NEVADA
County of Clark

x [Signature]
Original Signature of Applicant

Subscribed and Sworn to before me this 28th day of March 2019

Dailin Carmenate-Rivas

[Signature]
Notary Public



Applicant's initial DCR

ADDITIONAL INFORMATION

A series of horizontal dotted lines for writing.

Applicant's initial DCR Page 10

8B

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$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.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: MP or MW _____)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: MDRX, LLC

Physical Address: 118 Corporate Park Dr Ste#105
(This must be a business address, we can not issue a license to a home address)

Mailing Address: _____

City: Henderson State: NV Zip Code: 89074

Telephone: 1-866-700-6379 Fax: 1-702-802-2161

E-mail: f.malinis@mdrxdispense.com Website: www.mdrxdispense.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 6pm Tue: 9am to 6pm Wed: 9am to 6pm Thu: 9am to 6pm

Fri: 9am to 6pm Sat: 9am to 3pm Sun: 9am to 3pm Holidays: varies

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Becky Zawacki

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

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medical Gases** | <input checked="" type="checkbox"/> Assistive Equipment |
| <input checked="" type="checkbox"/> Respiratory Equipment** | <input checked="" type="checkbox"/> Parenteral and Enteral Equipment** |
| <input checked="" type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input checked="" type="checkbox"/> Diabetic Supplies | Other: _____ |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Frances Malinis Telephone: 702-580-8794

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

<u>pending licensure</u>	_____	_____
_____	_____	_____
_____	_____	_____

- 1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes No

- 2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes No

- 3) Are any of the owners health professionals? If yes, please check the box and list name.

- Practitioner
- Advanced Practitioner of Nursing
- Physician's Assistant
- Physical Therapist
- Occupational Therapist
- Registered Nurse
- Respiratory Therapist

Name:	_____
Name:	_____
Name:	_____
Name:	_____
Name:	_____
Name:	_____
Name:	_____

N/A

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

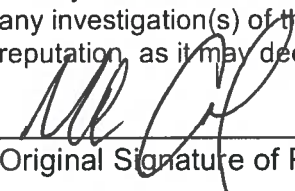
Within the last five (5) years:

- 1) Has the corporation, any owner, 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 MDEG provider or wholesaler may be grounds for the revocation of this permit.

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



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

Mark Casal
Print Name of Authorized Person

6/10/2019
Date

Board Use Only	Received: _____	Amount: <u>500.00</u>
-----------------------	-----------------	-----------------------

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICLY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Corporation Name: MDRX, LLC

Mailing Address: 118 Corporate Park Dr Ste#105

City: Henderson State: NV Zip: 89074

Telephone: 1-866-700-6379 Fax: 1-702-802-2161

Contact Person: Frances Malinis

For any corporation non publicly traded, disclose the following:

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

a)	<u>N/A</u>	
	Name	Address

b)	<u>N/A</u>	
	Name	Address

c)	<u>N/A</u>	
	Name	Address

d)	<u>N/A</u>	
	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. N/A

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

4) What date did the corporation actually receive the cash assets? N/A

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

SECRETARY OF STATE



CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, Barbara K. Cegavske, the duly elected and qualified 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, corporation soles, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada Revised Statutes which are either presently in a status of good standing or were in good standing 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, **MDRX, LLC**, as a limited liability company duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since December 26, 2013, and is in good standing in this state.

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

Barbara K. Cegavske
Secretary of State



Electronic Certificate
Certificate Number: C20190610-1702



List of Officers

Mark Casal, Officer

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 06/11/2019

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 MDEG
Nature of License
MDRX LLC 118 Corporate Park Dr Ste#105 Henderson, NV 89074
Name and Address of Establishment for Which License Is Requested
N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Casal		Mark	Anthony	
Last Name		First Name	Middle Name	
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)				
Burclare Ct		Sugarland	TX, 77479	
Present Residence Address-Street or RFD		City	State/Zip	
118 Corporate Park Dr Ste#105		Henderson	NV, 89074	
Present Business Address		City	State/Zip	
Pharmacist		Dates	2006-Present	
Occupation		Quezon City, Philippines	Phone: Residence	
			Business	866-700-6379
Date of Birth	42	Place of Birth (City, County, State)	Male	
Age	Brown	Social Security Number	White	215lbs
Color of Eyes	Color of Hair	Complexion	Weight	Build
				Large
				6'2"
				Height

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

Are you a citizen of the United States? Yes No If alien, registration No N/A

If naturalized, certificate No N/A Date N/A

Place N/A (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single Married Separated Divorced Widowed Engaged

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage** 3/19/2005 Houston, Harris, TX
Date City, County and State
 Spouse's full name (Maiden) Roxana Yvonne Hidalgo !
S.S. No.
 Date of Birth _____ Place of Birth Houston, TX
 Resident address 3 Burclare Ct Sugarland TX 77479
Street City State Zip
 Telephone: Residence ! Business 931-520-1001
 Spouse's employer Infinity Pharmacy, LLC Occupation Business Manager
 Address of employer 1080 Neal St Ste#100 Cookeville TN 38501
Street City State Zip

B. Previous Marriages: If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
N/A				

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

Name	Street	City	State	Zip	Telephone
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
Bella Rose Casal		Cookeville, TN	Burclare Ct Sugarland, TX 77479
Khloe Grace Casal		Cookeville, TN	Burclare Ct Sugarland, TX 77479
Talan Manuel Casal		Houston, TX	Burclare Ct Sugarland, TX 77479

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 MC

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			
Manuel Casal		Union Gap Rd Las Vegas, NV 89125	Deceased
Mother			
Belma Casal		3 Tyndrum Ave Henderson, NV 89044	Retired
Father-in-Law			
Arturo Hidalgo		Braewin Ct Houston, TX 77068	Deceased
Mother-in-Law			
Rosario Sandoval		Braewin Ct Houston, TX 77068	Deceased

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 Casal		Stonebridge Cir Cookeville, TN 38501	Physician
Spouse			
Gladys Casal		1 Stonebridge Cir Cookeville, TN 38501	Housewife
Max Casal		4 Brands Hatch Ct Henderson, NV 89052	Entrepreneur
Spouse			
Delsa Casal		Brands Hatch Ct Henderson, NV 89052	Housewife
Marcelino Casal		Tyndrum Ave Henderson, NV 89044	Pharmacist
Spouse			
Mellonie Casal		Tyndrum Ave Henderson, NV 89044	Housewife
Melissa Maglalang		Beardsley Cir Henderson, NV 89032	Attorney
Spouse			
Francis Maglalang		Beardsley Cir Henderson, NV 89032	Entrepreneur

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School Jordan Junior High	Burbank, CA	'83-'89	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School John Borroughs H.S.	Sugarland, TX	-91-'93	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
School John Foster Bolles H.S.		'93-'95	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University of Houston	Houston, TX	'95-'02	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other <u>N/A</u>			Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any Pharm D

College or university where obtained University of Houston

Applicant's initial 

5 MILITARY INFORMATION:

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

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

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

Rating at separation N/A Serial number N/A

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

B. Have you registered for the draft? Yes No

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

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

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

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

- B. Has a criminal indictment, information or complaint ever been returned against you, but for which you were not arrested or in which you were named as an unindicted co-party? Yes No If yes, furnish details on page 10.
- C. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission or committee? Yes No
- D. Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or commission? Yes No
- E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes No
- F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes No
If yes, when? N/A city, county and state N/A
- G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes No
If yes when? N/A city, county and state N/A
- H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes No
If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date
N/A				

Applicant's initial Mc Page 4

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

- I. Have you, as an individual, member of a partnership, or owner, director or officer of a corporation. ever been a part to a lawsuit as either a plaintiff or defendant or an arbitration as either a claimant or respondent?
 Yes No (Other than divorces)
 If yes, give details below. List all cases without exception, including bankruptcies:

Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
N/A				


- J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
 Yes No If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
N/A		

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
01/12-Present	Burclare Ct	Sugarland	TX
01/06-01/12	2116 Boxwood Cir	Cookeville	TN
06/03-01/06	8912 Sungate Dr	Pearland	TX

Applicant's initial  Page 5

8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
January 2006	Infinity Pharmacy, LLC 1080 Neal St Ste#100 Cookeville, TN 38501	
Title	Description of Duties	Name of Supervisor
Pharmacist/Owner	Manage Pharmacy	N/A
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
June 2003	Texas Children's Hospital 6621 Fannin St Houston, TX 77030	
Title	Description of Duties	Name of Supervisor
Pharmacist	Verify Prescriptions	Linh Nguyen
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
May 2002	Walgreens Houston, TX	Resigned-better opportunity
Title	Description of Duties	Name of Supervisor
Pharmacist	Verify Prescriptions, Perform Consultations	Lattifany Sauls
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor

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

Applicant's initial 

9. CHARACTER REFERENCES:

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

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Bamron Jonathan	Home	Glenlock St Sugarland, TX 77479				20 years
Employer University AmericanBusiness		Houston, TX			832-226-2052	
Name Ray Kwan	Home	Pery St Sugarland, TX 77479				23 years
Employer MD Anderson	Business	Houston, TX			832-423-2729	
Name Jimmy Lin	Home	Glistening Cloud Dr Henderson, NV 89012				23 years
Employer Self	Business	Las Vegas, NV			702-947-0940	
Name Jim Promobol	Home	N Wellington Ct Houston, TX 77055				24 years
Employer Shell	Business	Houston, TX			832-265-0235	
Name Sara Smith	Home	2 Idlewind Dr Richmond, TX 77406				24 years
Employer FRISD	Business	Sugarland, TX			201-615-0242	

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			


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

Pharmacist, TN, 19 years

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.

Infinity Pharmacy, LLC

1080 Neal St Ste#100 Cookeville, TN 38501

Applicant's initial 

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

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

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

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

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

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

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

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

Marcelino Casal-Pharmacist



Date of photograph 06/11/2019

Applicant's initial *MC*

STATE OF Nevada

ss.

COUNTY OF Clark

I, Mark Casal, 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 or fraudulent," and further, that I have familiarized myself with the contents of Nevada Statutes on Pharmacists and Manufacturer and the Controlled Substances Act, as amended, and the Regulations of the Nevada State Board of Manufacturer as promulgated thereunder and agree, if licensed, to abide thereby,

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

[Handwritten signature of Mark Casal]

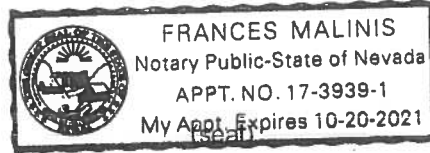
Original Signature of Applicant

Subscribed and Sworn to before me this 11th day of June 2019

Frances Malinis

[Handwritten signature of Frances Malinis]

Notary Public




Applicant's initial

[Handwritten initials]

ADDITIONAL INFORMATION

[A series of horizontal dotted lines for writing additional information.]

Applicant's initial  Page 10

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 6/10/19

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, 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.

All applicants are advised that this application to be a MDEG administrator 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 mDEG Supplier

mDEX LLC 118 Corporate Park Dr. Ste #105 Henderson NV 89074
 Name and Address of Business for Which MDEG Administrator Is Requested

.....
 If applicable, Name Under Which It Is Now Operated

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

8/2016 - Present	MdRx, LLC	Approx 5400
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Designated Representative	customer service, process orders receive orders	Mark Casal
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor

I have I have not been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

- 1. I have I have not been charged, arrested or convicted of a felony or misdemeanor.
- 2. I have I have not been the subject of an administrative action whether completed or pending.
- 3. I have I have not had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked "I have" to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: N/A
b) Date: N/A

Case Number: N/A

c) Criminal Action: State: N/A

Date: N/A

Case Number: N/A

County: N/A

Court: N/A

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes No

5 .Will you be employed fulltime with the MDEG? Yes No

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes No

If you answer No to questions 4, 5 or 6 please provide a \

N/A
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PH
ST

Date of photograph 6/10/19

I, Becky Zawaeki, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant "Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent," and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

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 MDEG in the State of Nevada.

Becky Zawaeki
Original Signature of Applicant

8C

NEVADA STATE BOARD OF PHARMACY

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

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$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.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: MP or MW _____)			

<input type="checkbox"/> Publicly Traded Corporation □ Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation □ Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner □ Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Providence Medical Supply

Physical Address: 1729 E Charleston Blvd # F Las Vegas 89104
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1729 E Charleston Blvd # F

City: Las Vegas State: NV Zip Code: 89104

Telephone: 702-982-0078 Fax: 702 485 6332

E-mail: Dupeb@yahoo.com Website: N/A

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 6 Tue: 9 to 6 Wed: 9 to 6 Thu: 9 to 6

Fri: 9 to 6 Sat: closed to Sun: closed to Holidays: closed to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Modupe Ivorobeje

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

- | | |
|---|--|
| <input type="checkbox"/> Medical Gases** | <input checked="" type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input checked="" type="checkbox"/> Diabetic Supplies | Other: _____ |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: _____ Telephone: _____

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

List all Medicare and Medicaid provider numbers registered to the business or its owner:

<u>1558824607</u>	_____	_____
<u>1154703905</u>	_____	_____
_____	_____	_____

1) Do any shareholders hold an interest ownership or have management in any type of business or facility which are licensed by the State of Nevada or another political jurisdiction? Yes No

2) Are you or have you in the last year been associated with any person, business or health care entity in which MDEG products were sold, dispensed or distributed? Yes No

3) Are any of the owners health professionals? If yes, please check the box and list name.

<input type="checkbox"/> Practitioner	Name: _____
<input type="checkbox"/> Advanced Practitioner of Nursing	Name: _____
<input type="checkbox"/> Physician's Assistant	Name: _____
<input type="checkbox"/> Physical Therapist	Name: _____
<input type="checkbox"/> Occupational Therapist	Name: _____
<input type="checkbox"/> Registered Nurse	Name: _____
<input type="checkbox"/> Respiratory Therapist	Name: _____

Practicing licensed health care professionals cannot obtain a license per NAC 639.6943.

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

- 1) Has the corporation, any owner, 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 MDEG provider or wholesaler may be grounds for the revocation of this permit.

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

[Handwritten Signature]

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

MOBULE IRORO BEJE

Print Name of Authorized Person

4/10/2019

Date

Board Use Only	Received: _____	Amount: <u>500.00</u>
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APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICLY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: N/A

Corporation Name: Divine Providence Inc

Mailing Address: 11055 Kilkenny Ct

City: Las Vegas State: NV Zip: 89141

Telephone: 9546631759 Fax: _____

Contact Person: D. Modupe Ironsbeje

For any corporation non publicly traded, disclose the following:

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

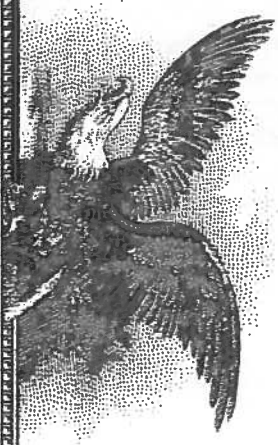
- 100% a) Modupe Ironsbeje 11055 Kilkenny Ct. Las Vegas 89141
- Name Address
- b) _____
- Name Address
- c) _____
- Name Address
- d) _____
- Name Address

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

- 2) Provide the number of shares issued by the corporation. 75,000
- 3) What was the price paid per share? No Par Value
- 4) What date did the corporation actually receive the cash assets? 03/20/2013
- 5) Provide a copy of the corporation's stock register evidencing the above information

NUMBER 75,000

SHARES 100%



DIVINE PROVIDENCE INC.

INCORPORATED UNDER THE LAWS OF THE STATE OF NEVADA 2013
AUTHORIZED CAPITAL SEVENTY FIVE THOUSAND (75,000) SHARES OF COMMON STOCK WITH NO PAR VALUE

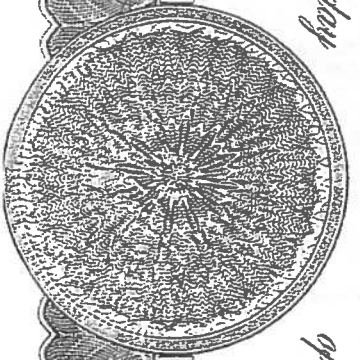
This certifies that Madge Ivatsky *is the*
registered holder of _____ *Shares*

FULLY PAID AND NON-ASSESSABLE SHARES OF THE CAPITAL STOCK OF SAID CORPORATION
transferrable only on the books of the Corporation by the holder hereof in person or by attorney upon surrender of this certificate properly endorsed.

In Witness Whereof, the said Corporation has caused this Certificate to be signed by its duly authorized officers and its Corporate Seal to be hereunto affixed this 20th *day* Nov *of* 2013

[Signature]
SECRETARY

[Signature]
PRESIDENT



(PROFIT) INITIAL/ANNUAL LIST OF OFFICERS, DIRECTORS AND STATE BUSINESS LICENSE APPLICATION OF:

DIVINE PROVIDENCE INC
NAME OF CORPORATION

ENTITY NUMBER
E0137082013-1

FOR THE FILING PERIOD OF **MAR, 2019** TO **MAR, 2020**



USE BLACK INK ONLY - DO NOT HIGHLIGHT

****YOU MAY FILE THIS FORM ONLINE AT www.nvsilverflume.gov****

Return one file stamped copy. (If filing not accompanied by order instructions, file stamped copy will be sent to registered agent.)

IMPORTANT: Read instructions before completing and returning this form.

1. Print or type names and addresses, either residence or business, for all officers and directors. A President, Secretary, Treasurer, or equivalent of and all Directors must be named. There must be at least one director. An Officer must sign the form. **FORM WILL BE RETURNED IF UNSIGNED.**
2. If there are additional officers, attach a list of them to this form.
3. Return the completed form with the filing fee. Annual list fee is based upon the current total authorized stock as explained in the Annual List Fee Schedule For Profit Corporations. A \$75.00 penalty must be added for failure to file this form by the deadline. An annual list received more than 90 days before its due date shall be deemed an amended list for the previous year.
4. State business license fee is \$500.00/\$200.00 for Professional Corporations filed pursuant to NRS Chapter 89. Effective 2/1/2010, \$100.00 must be added for failure to file form by deadline.
5. Make your check payable to the Secretary of State.
6. **Ordering Copies:** If requested above, one file stamped copy will be returned at no additional charge. To receive a certified copy, enclose an additional \$30.00 per certification. A copy fee of \$2.00 per page is required for each additional copy generated when ordering 2 or more file stamped or certified copies. Appropriate instructions must accompany your order.
7. Return the completed form to: Secretary of State, 202 North Carson Street, Carson City, Nevada 89701-4201, (775) 684-5708.
8. Form must be in the possession of the Secretary of State on or before the last day of the month in which it is due. (Postmark date is not accepted as receipt date.) Forms received after due date will be returned for additional fees and penalties. Failure to include annual list and business license fees will result in rejection of filing.

Filed in the office of <i>Barbara K. Cegavske</i> Barbara K. Cegavske Secretary of State State of Nevada	Document Number 20190192003-97
	Filing Date and Time 05/01/2019 12:03 PM
	Entity Number E0137082013-1

(This document was filed electronically.)
ABOVE SPACE IS FOR OFFICE USE ONLY

CHECK ONLY IF APPLICABLE AND ENTER EXEMPTION CODE IN BOX BELOW

- Pursuant to NRS Chapter 76, this entity is exempt from the business license fee. Exemption code: **NRS 76.020 Exemption Codes**
NOTE: If claiming an exemption, a notarized Declaration of Eligibility form must be attached. Failure to attach the Declaration of Eligibility form will result in rejection, which could result in late fees.
 001 - Governmental Entity
 006 - NRS 680B.020 Insurance Co
- This corporation is a publicly traded corporation. The Central Index Key number is:
- This publicly traded corporation is not required to have a Central Index Key number.

NAME MODUPE A IROBOBEJE	TITLE(S) PRESIDENT (OR EQUIVALENT OF)
ADDRESS 1 1055 KILKERRAN COURT	CITY STATE ZIP CODE LAS VEGAS NV 89141
NAME MODUPE A IROBOBEJE	TITLE(S) SECRETARY (OR EQUIVALENT OF)
ADDRESS 1 1055 KILKERRAN COURT	CITY STATE ZIP CODE LAS VEGAS NV 89141
NAME MODUPE A IROBOBEJE	TITLE(S) TREASURER (OR EQUIVALENT OF)
ADDRESS 1 1055 KILKERRAN COURT	CITY STATE ZIP CODE LAS VEGAS NV 89141
NAME MOUPE A IROBOBEJE	TITLE(S) DIRECTOR
ADDRESS 1 1055 KILKERRAN COURT	CITY STATE ZIP CODE LAS VEGAS NV 89141

None of the officers or directors identified in the list of officers has been identified with the fraudulent intent of concealing the identity of any person or persons exercising the power or authority of an officer or director in furtherance of any unlawful conduct.

I declare, to the best of my knowledge under penalty of perjury, that the information contained herein is correct and acknowledge that pursuant to NRS 239.330, it is a category C felony to knowingly offer any false or forged instrument for filing in the Office of the Secretary of State.

X MODUPE A IROBOBEJE
Signature of Officer or Other Authorized Signature

Title **PRESIDENT** Date **5/1/2019 12:03:14 PM**

SECRETARY OF STATE



NEVADA STATE BUSINESS LICENSE

DIVINE PROVIDENCE INC
Nevada Business Identification # NV20131166246

Expiration Date: March 31, 2020

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.



IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on May 1, 2019

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law cannot be waived.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 4/10/19

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, 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.

All applicants are advised that this application to be a MDEG administrator 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 Medical Supply

Providence Medical Supply 1729 E Charleston Blvd #F
Name and Address of Business for Which MDEG Administrator Is Requested 89104

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Ivorobeje Modupe Ajoke
Last Name First Name Middle Name
Braithwaite

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

Kilkman Ct Las Vegas NV 89141
Present Residence Address-Street or RFD City State/Zip

1729 E Charleston Blvd Las Vegas NV 89104
Present Business Address City State/Zip

Administrator 2013- Present
Present Position with the MDEG

Phone: 702 982 6678 Fax: 702 985 6332

Email address: Providence medical supply1@gmail.com

Lagos, Nigeria
Date of Birth Place of Birth (City, County, State)

39 170 F
Age Social Security Number Sex

Brown Black 5'3"
Color of Eyes Color of Hair Weight Height

Scars, tattoos or distinguishing marks and/or characteristics None

Are you a citizen of the United States? Yes No

If alien, registration No _____

If naturalized, certificate No _____ Date 02/21/2013

Place Las Vegas NV (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

11/2013 - Present	1729 E Charleston Blvd #F Las Vegas NV 89104 Providence Pharmacy	45 hours/week
Pharmacist	verification of Medications & supplies to patients	Madhul Inwotsegi

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

Month and Year Name/ Address of Employer/Business No of Employed Hours

Title Description of Duties Name of Supervisor

I have I have not been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

- 1. I have I have not been charged, arrested or convicted of a felony or misdemeanor.
- 2. I have I have not been the subject of an administrative action whether completed or pending.
- 3. I have I have not had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked I have to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes No

5 .Will you be employed fulltime with the MDEG? Yes No

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes No

If you answer No to questions 4, 5 or 6 please

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explanation.

PHOTOGRAPH

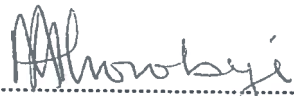
WITHIN LAST

30 DAYS HERE

Date of photograph 4/29/19

I, Modupe Ironsbeji, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient cause for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent, and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

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 MDEG in the State of Nevada.



 Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 4/15/19

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 DME (MDEG)
Providence Medical Supply ^{Nature of License} 1729 E Charleston Blvd #F Las Vegas 89104
Name and Address of Establishment for Which License Is Requested
N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Iroboje Modupe Ayole
Last Name First Name Middle Name
Braithwaite

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

Kilkerran Ct Las Vegas NV 89141
Present Residence Address-Street or RFD City State/Zip

1729 E Charleston Blvd Las Vegas NV 89104
Present Business Address City State/Zip

Pharmacist 2013 - Present
Occupation Dates

Phone: Residence 702-982-0078
Business
Lagos, Nigeria
Date of Birth Place of Birth (City, County, State)

39 Female
Age Sex

Brown Black Black 170 Average 5'3"
Color of Eyes Color of Hair Complexion Weight Build Height

Scars, tattoos or distinguishing marks and/or characteristics None

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

If naturalized, certificate No. 1001 Date 2/22/2013

Place Las Vegas NV (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single Married Separated Divorced Widowed Engaged

Applicant's initial MAI Page 1

MARITAL INFORMATION-Continued

A. **Current Marriage** 12/13/2007 Las Vegas, Clark, NV
 Spouse's full name (Maiden) Friday Irobegi Date 12/13/2007 City, County and State Las Vegas, Clark, NV
 Date of Birth _____ Place of Birth Ughelli, Nigeria S.S. No. _____
 Resident address Killarwan Ct Las Vegas NV 89141
 Street City State Zip
 Telephone: Residence _____ Business 702 945 4262
 Spouse's employer HealthCare Partners Occupation Nurse Practitioner
 Address of employer 821 N Nellis Blvd Las Vegas NV 89110
 Street City State Zip

B. **Previous Marriages:** If ever legally separated, divorced, or annulled, indicate below:

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
N/A				

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

Name	Street	City	State	Zip	Telephone
N/A					

3. **FAMILY INFORMATION:**

A. **Children and Dependents:**

List all children, including step-children and adopted children and give the following information:

Name	Birth Date	Birth Place	Residence Address
<u>Jeremiah Irobegi</u>	<u>12/13/2007</u>	<u>Las Vegas NV</u>	<u>Killarwan Ct Las Vegas NV 89141</u>
<u>Oghene Yoma Irobegi</u>	<u>11/11/2007</u>	<u>Las Vegas NV</u>	<u>Killarwan Ct Las Vegas NV 89141</u>
<u>Oghenemini Irobegi</u>	<u>11/11/2007</u>	<u>Las Vegas NV</u>	<u>Killarwan Ct Las Vegas NV 89141</u>

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 MAI

FAMILY INFORMATION-Continued

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

Name
 Address
 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 Bankole Braithwaite		Deceased	
Mother Ceila Thomas		Kilkunan Ct Las Vegas 89171	Retired
Father-in-Law Michael Inwobeji		Akpodiete St. Ughelli North Delta State	Retired
Mother-in-Law Grace Inwobeji		Akpodiete St. Ughelli North Delta State	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
Mobolaji Braithwaite		Miami Drive FL 33162	Customer Service
Spouse Sybil Braithwaite		Miami Drive FL 33162	House wife
Spouse			
Spouse			
Spouse			

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School Maryland Convent Primary School		1985-1991	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School Maryland Comprehensive Sec. School		1991-1997	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University Florida Memorial University			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other Miami Gardens FL 33054			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any..... PharmD 2007-2010

College or university where obtained..... Roseman College of Health Sciences
 11 Senses way Henderson W 89014

Applicant's initial..... NMT

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 _____ State _____ Date registered _____

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

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

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

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

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

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

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

F. Have you ever had a civil or criminal record expunged or sealed by a court order? Yes No If yes, when? _____ city, county and state _____

G. Have you ever received a pardon or deferred prosecution for any criminal offense? Yes No If yes when? _____ city, county and state _____

H. Has any member of your family or of your spouse's family ever been convicted of a felony? Yes No If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Name	Relationship	Charge	Location	Date
N/A				

Applicant's initial NMAE

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
Defendant Bankruptcy	4/12/2010	10-16337-Mkn	Las Vegas NV	7/21/2010

- J. Has any general partnership, business venture, sole proprietorship or closely held corporation (while you were associated with it as an owner, officer, director or partner) been a party to a lawsuit, arbitration or bankruptcy?
 Yes No If yes, complete the following:

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
N/A		

7. RESIDENCES:

List all residences you have had for the last 25 years:

Month and Year (From-To)	Street and Number	City	State or County
05/2003 - 08/2005	18068 SW 36th Ct	Miami	FL 33029
08/2005 - 08/2007	1020 NW 155 Ave	Miami	FL 33054
08/2007 - 12/2007	1100 N Center St	Henderson	NV 89015
01/2008 - 04/2011	5501 E Harmon Ave	Las Vegas	NV 89122
05/2011 - 12/2017	3540 Tundra Swan St.	Las Vegas	NV 8912
12/2017 - Present	Killman Ct.	Las Vegas	NV 89141

Applicant's initial MMF
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8. EMPLOYMENT:

Beginning with your current employment, list your work history, all businesses with which you have been involved, and/or all periods of unemployment since 18 years of age. Also, list all corporations, partnerships or any other business ventures with which you have been associated as an officer, director, stockholder or related capacity.

Month and Year 11/2013 - 04/14	Name/Mailing Address of Employer/Business Providence Pharmacy	Reason for Leaving Sold the business
Title Pharmacist	Description of Duties Pharmacy Manager	Name of Supervisor Modupe Iwosiji
Month and Year 01/12 - 08/14	Name/Mailing Address of Employer/Business Walmart Pharmacy	Reason for Leaving left to open my business
Title Pharmacist	Description of Duties Pharmacist	Name of Supervisor
Month and Year 10/2010 - 01/2012	Name/Mailing Address of Employer/Business CVS Pharmacy	Reason for Leaving switched companies
Title Pharmacist	Description of Duties Pharmacist	Name of Supervisor Rhonda Lindsay
Month and Year 04/2011 - 10/2011	Name/Mailing Address of Employer/Business Advanced Care Pharmacy	Reason for Leaving Part time
Title Pharmacist	Description of Duties 4161 Stearns Avenue Las Vegas NV 89119	Name of Supervisor Jenny
Month and Year 05/2005 - 04/2006	Name/Mailing Address of Employer/Business Interactive Response Technology	Reason for Leaving
Title Customer Service Rep.	Description of Duties 2989 N. Commerce Blvd. answering questions about phone services	Name of Supervisor Karin
Month and Year 05/1998 - 04/2005	Name/Mailing Address of Employer/Business Full time Student	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	Description of Duties	Name of Supervisor

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

Applicant's initial MAI
Page 6

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 Nazatene Zeban	Home				Tehn Ranch Ave 89052	7 years
Employer	N/A				N/A	
Name Felix Egbise	Home				Opal Cove Drive 89128	10 years
Employer Kindred Hosp	Business				5110 W Sahara Las Vegas 89146	
Name Zeb Igekle	Home				S Rambow Blvd # 110 89145	10 years
Employer Alpha O Accounting	Business				222 S Rambow Blvd # 110 89145	
Name Rose Stiffin	Home				NW 42nd Avenue #133054	16 years
Employer Florida International University	Business				University Professor	
Name Annette Ouedraogo	Home				3 Hunter Chase Dr #424 78729	15 years
Employer State of Texas	Business				Accounting	

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			

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

N/A

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

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

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

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

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

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

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

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



Date of photograph 4/29/19

Applicant's initial MATF

STATE OF Nevada

ss.

COUNTY OF Clark

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

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

Moshupe Ironbeji
Original Signature of Applicant

Subscribed and Sworn to before me this 1st day of May 2019

Mariam Jane Hasso
Notary Public



(seal)

Applicant's initial MAI

ADDITIONAL INFORMATION

N/A