

# NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509

## APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

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

Application must be printed legibly or typed

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

☒ New Pharmacy or ☐ Ownership Change (Provide current license number if making changes: PH\_\_\_\_)  
Check box below for type of ownership and complete all required forms.  
☐ Publicly Traded Corporation – Pages 1,2,3,7 ☐ Partnership – Pages 1,2,5,7  
☐ Non Publicly Traded Corporation – Pages 1,2,4,7 ☐ Sole Owner – Pages 1,2,6,7

### GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: PROMISE PHARMACY

Physical Address: 318 18 US Hwy 19 N

Mailing Address: \_\_\_\_\_

City: Palm Harbor State: FL Zip Code: 34684

Telephone: 727-772-0500 Fax: 727-772-0511

Toll Free Number: 888 377-6677 (Required per NAC 639.708)

E-mail: info@Promisepharmacy.com Website: www.Promisepharmacy.com

Managing Pharmacist: JiYANG Chung License Number: 51110

### TYPE OF PHARMACY

AND

### SERVICES PROVIDED

Yes/No

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

All boxes must be checked

For the application to be complete

Yes/No

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

\*\*If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,

## APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

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

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

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

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

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

CRAIG BACHLOR  
Print Name of Authorized Person

12/14/12  
Date

Page 2

Board Use Only

Date Processed: \_\_\_\_\_

Amount: \$500.00

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

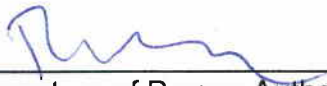
I, Rink Patel

Responsible Person of Promise Pharmacy

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.



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

Rink Patel

Print Name of Authorized Person

12/15/2017

Date

# APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

## OWNERSHIP IS A PARTNERSHIP

General \_\_\_\_\_

Limited ☒

Partnership Name: ~~THE~~ Promise Pharmacy LLC

Mailing Address: 31818 US 19 N

City: Palm Harbor

State: FL

Zip Code: 34684

Telephone Number: 727-772-0500

Fax Number: 727-772-0511

Contact Person: Craig Bachler

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

Name

G or L

Percentage

Dipti Patel 3190 Hamblin way

Wellington FL 33414

G

100%

List names of 4 largest partners and percentage of ownership:

Name: Dipti Patel

%, 100%

Name: \_\_\_\_\_

%, \_\_\_\_\_

Name: \_\_\_\_\_

%, \_\_\_\_\_

Name: \_\_\_\_\_

%, \_\_\_\_\_

List any physician shareholders and percentage of ownership.

Name: N/A

%, 0

Name: \_\_\_\_\_

%, \_\_\_\_\_

Name: \_\_\_\_\_

%, \_\_\_\_\_

## Hours of Operation for the pharmacy:

Monday thru Friday 9 am 6:30 pm

Saturday \_\_\_\_\_ am \_\_\_\_\_ pm

Sunday \_\_\_\_\_ am \_\_\_\_\_ pm

24 Hours \_\_\_\_\_

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

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

**Rick Scott**

Governor

**Celeste Phillip, MD, MPH**

Surgeon General and Secretary

**Vision:** To be the Healthiest State in the Nation

December 4, 2017

Promise Pharmacy  
Attn: Jacki Thibodeau  
31818 US Hwy 19N  
Palm Harbor, FL 34684

RE: License Certification for Promise Pharmacy, LLC

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Pharmacy
LICENSE NUMBER:	PH22007
ORIGINAL CERTIFICATION:	05/16/2006
EXPIRATION DATE:	02/28/2019
CURRENT STATUS OF LICENSE:	CLEAR,
AGENCY ACTION:	No

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595, option 5.

Sincerely,

Tiquitta Floyd  
Regulatory Specialist II

/TF

**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of Operations  
4052 Bald Cypress Way, Bin C10 • Tallahassee, FL 32399-3251  
PHONE: (850) 488-0595 • FAX: (850) 245-4791



**Accredited Health Department**  
Public Health Accreditation Board



## Department of Health

License Number: PH22007

*Data As Of 12/14/2017*

<b>Profession</b>	Pharmacy
<b>License</b>	PH22007
<b>License Status</b>	CLEAR/
<b>Qualifications</b>	Community Pharmacy Schedule II & III
<b>License Expiration Date</b>	2/28/2019
<b>License Original Issue Date</b>	05/16/2006
<b>Address of Record</b>	31818 US 19 PALM HARBOR, FL 34684
<b>Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)</b>	No
<b>Discipline on File</b>	No
<b>Public Complaint</b>	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.



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### GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: CD Pharmacy LLC dba Red Rock Pharmacy

Physical Address: 1240 E 100S Unit 220, Saint George, UT, 84790

Mailing Address: 450S 900E #150, Salt Lake City, UT, 84102

City: Saint George State: UT Zip Code: 84790

Telephone: 435-703-2900 Fax: 435-703-2903

Toll Free Number: 800-466-8273 (Required per NAC 639.708)

E-mail: redrock@redrockrx.com Website: www.redrockrx.com

Managing Pharmacist: Shuxian Wang License Number: 8421232-1701

### TYPE OF PHARMACY

### AND

### SERVICES PROVIDED

Yes/No

- ☐ ☒ Retail  
☐ ☒ Hospital (# beds \_\_\_\_)  
☐ ☒ Internet  
☐ ☒ Nuclear  
☐ ☒ Ambulatory Surgery Center  
☐ ☒ Community  
☒ ☐ Other: close door  
long-term care

All boxes must be checked  
For the application to be complete

Yes/No

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

\*\*If you check "yes" on any of these types of services, you will be required to make an appearance at the board meeting,

## APPLICATION FOR OUT-OF STATE PHARMACY LICENSE

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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

Kenneth Edgars NOTAS  
Print Name of Authorized Person

12/5/2017  
Date

Page 2

Board Use Only

Date Processed: \_\_\_\_\_

Amount: \$500.00



APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

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

Owner's Name: Kenneth Edare Norris (Kenneth Edare Norris)

Business Name: Red Rock Pharmacy

Current Business Address: 4505 900 E #150

City: Salt Lake City State: UT Zip Code: 84102

Telephone: 801-433-9500 Fax: 801-433-9333

List any physician shareholders and percentage of ownership.

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

Name: \_\_\_\_\_ %: \_\_\_\_\_

**Hours of Operation for the pharmacy:**

Monday thru Friday 9 am 6 pm

Saturday closed am \_\_\_\_\_ pm

Sunday closed am \_\_\_\_\_ pm

24 Hours on call

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



State of Utah  
Department of Commerce  
Division of Occupational and Professional Licensing

GARY R. HERBERT  
*Governor*

FRANCINE A. GIANI  
*Executive Director*

MARK B. STEINAGEL  
*Division Director*

## VERIFICATION OF UTAH LICENSURE

Created On: 12/11/2017

**This verification is considered a primary source from the State of Utah.**

**Name of Licensee (as it appears in our records):** CD Pharmacy LLC dba Red Rock Pharmacy

**Classification of License Issued:** Pharmacy - Class B

**License Number:** 10336168-1704

**Obtained By:** Application

**Current Status:** Active

**Original Date of Licensure:** 04/17/2017

**Expiration Date:** 09/30/2019

**Agency and Disciplinary Action:** NO

**Docket Number:** N/A

The information provided on this form is accurate and correct as of the verification creation date listed on the top of this form. Original issue dates listed, as 01/01/1910 and 01/01/1911 were unknown when the division implemented its first licensing database. This verification form does not show a complete history or interruptions in licensure. If you have any questions please contact the division.

[www.dopl.utah.gov](http://www.dopl.utah.gov) • Heber M. Wells Building • 160 East 300 South • PO Box 146741 • Salt Lake City • UT 84114-6741  
phone: (801)530-6628 • toll-free in Utah: (866)275-3675 • fax: (801)530-6511 • investigations fax: (801)530-6301

STATEMENT OF RESPONSIBILITY  
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, Kenneth Eddie Norris

Responsible Person of DBA Red Rock Pharmacy, CD Pharmacy LLC

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.



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

Kenneth Eddie Norris

Print Name of Authorized Person

12/5/2017  
Date