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.

☑ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW ______________)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☑ 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: A-Class Medical Supplies

Physical Address: 2001 South Jones Blvd Suite 1C Las Vegas, NV 89146
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 4325 Dean Martin Drive Suite 340

City: Las Vegas State: NV Zip Code: 89103

Telephone: 702-237-9984 Fax: 702-834-8490

E-mail: amadormedical@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: Closed to ____ Sun: Closed to ____ Holidays: Closed to ____

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Donaldo Amador

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

☐ Medical Gases** ☑ Assistive Equipment
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**
☐ Life-sustaining equipment** ☑ Orthotics and Prosethics
☐ Diabetic Supplies Other: Incontinence Supplies

**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: ______________

93209

APPLICATION FOR NEVADA MDEG LICENSE

<u>This page must be submitted for all types of ownership.</u>

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

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

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 Name: ____________
- ☐ Advanced Practitioner of Nursing Name: ____________
- ☐ Physician's Assistant Name: ____________
- ☐ Physical Therapist Name: ____________
- ☐ Occupational Therapist Name: ____________
- ☐ Registered Nurse Name: ____________
- ☐ Respiratory Therapist Name: ____________

<u>Practicing</u> 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 ☑

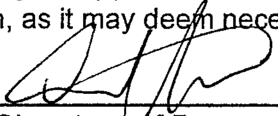
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☑

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

Donald Amador Juarez

Print Name of Authorized Person

6-20-16

Date

Board Use Only	Received: 6/28/16	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Donald Amador

Business Name: A-Class Medical Supplies

Current Business Address: 2001 South Jones Blvd Suite K

City: Las Vegas State: NV Zip: 89146

Telephone: 702-237-9984 Fax: 702-834-8480

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*.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 6/20/2016

GENERAL INSTRUCTIONS

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

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

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

Application for Durable Medical Equipment Prosthetics, Orthotics and Supplies
Nature of License

A-Class Medical Supplies 2001 South Jones Blvd Suite K Las Vegas, NV 89146
Name and Address of Establishment for Which License Is Requested

A-Class Medical Supplies
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Amador - Suarez | Donald | Rene
Last Name | First Name | Middle Name

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

6601 Socorro drive | Las Vegas | NV 89108
Present Residence Address-Street or RFD | City | State/Zip

2001 South Jones Blvd Ste K Dates 02-16-16 - Present | NV 89146
Present Business Address | City | State/Zip

Medical Supplies Dates 2-1-11
Occupation

Phone:
Residence
Business 702 724-1734

Date of Birth | Managua, Nicaragua
Place of Birth (City, County, State)

29 | Social Security Number | M
Age | | Sex

Brown	Brown	Fair	180	Medium	5'8
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

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

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

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

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☐ Married ☐ Separated ☐ Divorced ☑ Widowed ☐ Engaged ☐

Applicant's initial DA

MARITAL INFORMATION-Continued

A. **Current Marriage** N/A
Date — City, County and State

Spouse's full name (Maiden) ________ S.S. No ________

Date of Birth ________ Place of Birth ________

Resident address ________
Street — City — State — Zip

Telephone: Residence ________ Business ________

Spouse's employer ________ Occupation ________

Address of employer ________
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
Bradi Ward	12-30-08	12-30-08	Marriage	Las Vegas, Clark county,

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

Name	Street	City	State	Zip	Telephone
Bradi Ward	5252 Kootenai St	Boise,	id	83705	

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

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 DA

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	Juan Rene Amador Arrieta	N/A	Deceased	Deceased
Mother	Conny Margarita Suarez Espinoza		Km 14 Carretera Masaya, 600 Mts ~~Posta Veracruz~~ Residencial Monte Rosa Casa #27	Retired
Father-in-Law				
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
	Cairo Juan Amador Suarez			Systems Engineer
Spouse				
	Glen Amador		Jasmine Joy Ct	Owner of Vida Homec
Spouse				
	Juan Amador			
Spouse				
	Valeria Amador		1444 Monte Vista Street	Owner of Amador Care
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Colegio Faure	Nicaragua	1995-2001	Yes ☑ No ☐
High School	Colegio Bautista de Nicaragua	Nicaragua	2001-2006	Yes ☑ No ☐
College University				Yes ☐ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any N/A

College or university where obtained N/A

Applicant's initial DA

5 MILITARY INFORMATION:

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

Branch MA Date of entry-active service N/A

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

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 MA 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
MA					

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
MA				

Applicant's initial OA

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
1986 - 2007	Rotonda Bello Horizonte K-III-20	Managua, Nicaragua	
2007 - 2012	7300 Pirate cove rd Apt 2091	Las Vegas	NV 89145
2012 - 2014	7200 Pirate cove rd Apt 2111	Las Vegas	NV 89145
2014 - 2015	6593 Socorro drive	Las Vegas	NV 89108
2015 - 2016	6601 Socorro drive	Las Vegas	NV 89108

Applicant's initial ____________

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
03/15/09	Vida Accounting 2001 S. Jones Blvd Suite K	Started A Company

Title	Description of Duties	Name of Supervisor
Community Liason	Promoting Homecare Business	Glen Amador

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
May 2011	Amador Medical llc 4325 Dean Martin drive Suite 340 LV NV 89103	Still Active

Title	Description of Duties	Name of Supervisor
Administrator	Manage the Business	Glen Amador

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

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 Blanca Estela Arias Barahona	Home 3846 Chutney St Las Vegas NV 89121		6 y.
Employer MGM Grand	Business Kitchen work		
Name Claudia Orozco	Home 765 Rustic desert place Henderson NV 89011		
Employer Capital 1	Business Supervisor		
Name Cynthia Bernal	Home 6593 Socorro drive Las Vegas NV 89108		3
Employer Mirage Hotel & Casino	Business Security		
Name Melissa Arias	Home 6601 Socorro Drive Las Vegas NV 89108		
Employer Mandalay Bay Hotel	Business Casino Porter		
Name Fernando Jimenez	Home 9054 Mastodon Avenue 89149		10 years
Employer Above therapy UBCS	Business Administrator		

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 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.

Applicant's initial OA

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 6/17/2016

Applicant's initial DR

STATE OF Nevada ss.

COUNTY OF Clark

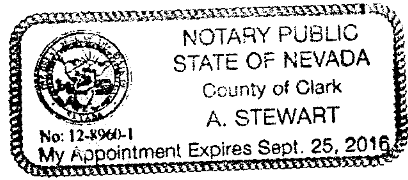
I, Donald Rene Amador Soarez, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge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

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

Original Signature of Applicant

Subscribed and Sworn to before me this 17 day of June 2016

Notary Public



(seal)

Applicant's initial DA

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 6/20/2016

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 herein 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 Orthotics and Supplies

Nature of MDEG

A-Class Medical Supplies 2001 South Jones Blvd Suite K Las Vegas NV 89146

Name and Address of Business for Which MDEG Administrator Is Requested

A-Class Medical Supplies

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Amador | Donaldo | Jose
Last Name | First Name | Middle Name

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

7147 South Durango Drive Apt 109 | Las Vegas | NV 89103
Present Residence Address-Street or RFD | City | State/Zip

2001 South Jones Blvd Suite 1C Dates 6/2016 | Las Vegas | NV 89146
Present Business Address | City | State/Zip

Manager Dates 6/2016
Present Position with the MDEG

Phone: 702 - 237-4484 Fax: 702-834-8490

Email address:

Date of Birth | Managua, Nicaragua
Place of Birth (City, County, State)

34 | | Male
Age | Social Security Number | Sex

Brown | Black | 235 | 5'11
Color of Eyes | Color of Hair | Weight | Height

Scars, tattoos or distinguishing marks and/or characteristics Tattoos on left shoulder and arm. Also tattoo on lower right leg

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.

5/2014-Current / Amador Medical 43[illegible] Dean Martin Drive Ste 340 — 4,000

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

Business Development Manager — Oversee day to day operations — Donald Amador

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:
b)

State: ______________________

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 wri

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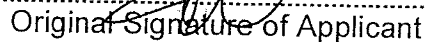
Date of photograph 10/20/2016

I, Donaldo Amador, 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 of 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

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.

☑ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW ________)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6
☑ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ 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 MEDICAL "R" US

Physical Address: 2475 S. JONES BLVD. LAS VEGAS, NV 89146
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 2475 S. JONES BLVD.

City: LAS VEGAS State: NEVADA Zip Code: 89146

Telephone: 702 453 3650 Fax: 702/453 3325

E-mail: ________ Website: none

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9:00 AM to 5:00 pm Tue: 9 AM to 5 pm Wed: 9 AM to 5 pm Thu: 9 AM to 5 pm

Fri: 9 AM to 5 pm Sat: 9 AM to 5 pm Sun: 9 AM to 5 pm Holidays: 9 AM to 5 pm

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Myrah Ventenilla

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

☐ Medical Gases**
☑ Respiratory Equipment**
☑ Life-sustaining equipment**
☑ Diabetic Supplies
☑ Assistive Equipment
☑ Parenteral and Enteral Equipment**
☑ Orthotics and Prosethics
Other: MEDICAL SUPPLIES

**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: [signature] JOHN PATRICK W. DELA ROSA Telephone: 702-427-1779

93200

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership. N/A Initial License

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

________	________	________
________	________	________
________	________	________

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.
No

☐ Practitioner	Name: ________
☐ Advanced Practitioner of Nursing	Name: ________
☐ Physician's Assistant	Name: ________
☐ Physical Therapist	Name: ________
☐ Occupational Therapist	Name: ________
☐ Registered Nurse	Name: ________
☐ 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 ☑

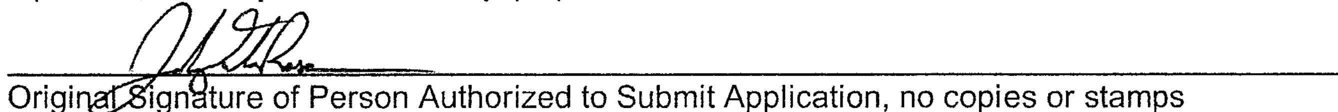
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☑

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

JOHN PATRICK W. DE LA ROSA — 12/18/15

Print Name of Authorized Person — Date

Board Use Only	Received: 6/28/16	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: N/A

Corporation Name: A&D Health care Solutions, Inc.

Mailing Address: 2475 S. Jones blvd #4

City: Las Vegas State: Nevada Zip: 89146

Telephone: 702 4833650 Fax: 702 4833325

Contact Person: John Patrick W. De La Rosa

For any corporation non publicly traded, disclose the following:

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

a) JOHN PATRICK W. DE LA ROSA 8877 Waltzing Water ct. Las Vegas, NV 89147
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 Applications" tab. The forms are available under the *documents for all types of businesses.*

2) Provide the number of shares issued by the corporation. 1,000-

3) What was the price paid per share? -0-

4) What date did the corporation actually receive the cash assets? 4/10/15

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

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/18/15

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 Medical Supplies & Equipment
Nature of License

All MEDICAL "R" US 2425 S Jones Bl STE. 4 LAS Vegas, NV 89146
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

DELA ROSA	John Patrick	WEBSTER
Last Name	First Name	Middle Name

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

8877 Waltzing Waters Ct	LAS VEGAS	NEVADA
Present Residence Address-Street or RFD	City	State/Zip
2475 S. Jones BLVD Dates	LAS VEGAS	NV 89146
Present Business Address	City	State/Zip

Dates

Occupation

Phone:
Residence
Business 702 48 33650

Date of Birth — Place of Birth (City, County, State)

22		male
Age	Social Security Number	Sex

Brown	Black		171 lbs.		5'9
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 Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

Single ☑ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐

Applicant's initial J.D.

MARITAL INFORMATION-Continued

A. **Current Marriage** .... Date .... City, County and State

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

Date of Birth .... N/A Place of Birth ....

Resident address ....
Street City State Zip

Telephone: Residence .... Business ....

Spouse's employer .... Occupation ....

Address of employer ....
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
none			

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 .... J.D.

FAMILY INFORMATION-Continued

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

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	MORENO DELA ROSA JR. -	/ /	8877 Waltzing Waters Ct. LV NV 89147	- Businessman
Mother	Elizabeth DELA ROSA -	/ /	- 8877 Waltzing Waters Ct. LV NV 89147	- Office manager/HR
Father-in-Law				
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
	MARIANNE DELA ROSA -	/ /	8877 Waltzing Waters Ct. LV NV 89147	- marketing
Spouse	Yan HUANG -		- Same	- Computer
	MORENO W. DELA ROSA III -	/ /	877 Waltzing Waters Ct. LV NV 89147	- part-time office clerk
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Eagle Canyon, Arrow Montessori	CA.	1998–2000, 2000–2006	Yes ☑ No ☐
High School	Ayala High School, Buena Vista High School	CA.	2007–2010, 2011	Yes ☑ No ☐
College University	CSN	LAS Vegas		Yes ☐ No ☑
Other	Community College		Currently taking college courses	Yes ☐ No ☑

Type of degree obtained, if any: Still in the process of getting AAS degree in Automotive

College or university where obtained: Currently in CSN college

Applicant's initial: J.D.

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? N/A 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.

N/A

Name	Relationship	Charge	Location	Date

Applicant's initial J.D.

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
11/2011 - Present	8000 Spring Mountain Rd.	Las Vegas	Nevada 89117
7/2011 - 11/2011	8877 Waltzing Waters Ct.	Las Vegas	Nevada 89117
10/1997 - 7/2011	13447 Misty Meadow Ct.	Chino Hills	California 91709

Applicant's initial J.D.

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
2013 - present	- Patient Care Home Health -	
Title	**Description of Duties**	**Name of Supervisor**
Data Entry/Adm. Asst.	Filing, Posting,	Connie Olveros
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
2012	GAP	
Title	**Description of Duties**	**Name of Supervisor**
Sales	Cashier/Customer Services	
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**
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 J.D.

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 Chande Pang	Home	Montclair	CA.	91763		8
Employer Vape Connex	Business					
Name Jim Ibarra	Home	Colton	CA	92324		8
Employer Falcon Abrasive manufacturing	Business					
Name Eugene Addo	Home	Washington	DC			8
Employer Metro Immediate Primary Care	Business					
Name	Home					
Employer	Business					
Name	Home					
Employer	Business					

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

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.

Applicant's initial JD

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 6/2/16

Applicant's initial J.D.

STATE OF Nevada

ss.

COUNTY OF Clark

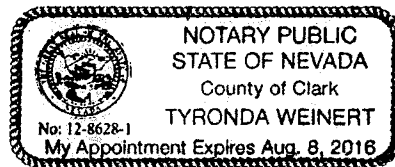
I, JOHN PATRICK W. DELA ROSA, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge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

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

Original Signature of Applicant

Subscribed and Sworn to before me this 18th day of December 2015

Notary Public



(seal)

Applicant's initial J.D.

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 12/18/15

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 SUPPLIES & EQUIPMENT

Nature of MDEG

ALL MEDICAL "R" US

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Ventenilla	Myrah	Manzo
Last Name	First Name	Middle Name

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

10201 Asti Place	Las Vegas	NV 89134
Present Residence Address-Street or RFD	City	State/Zip

Dates ______________________________
Present Business Address ______ City ______ State/Zip

Dates ______________________________
Present Position with the MDEG

Phone: ____________________ Fax: ____________________

Email address: ____________________ ____________________

	Los Angeles, CA	
Date of Birth	Place of Birth (City, County, State)	
28		F
Age	Social Security Number	Sex

brown	brown	130	5'5"
Color of Eyes	Color of Hair	Weight	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.)

Myrah Ventenilla

10201 Asti Place
Las Vegas, NV 89134

Solution oriented and versatile nurse with valuable skilled experience that includes interdisciplinary care team contribution, plan of care development, detailed assessments, and patient advocacy. Combine strong administration and nursing management skills with accountability for positive patient outcomes. Highly developed organizational skills and great attention to detail. Compassionate patient advocate who demonstrates caring professionalism when working with patients and their families.

Education:

El Monte Rosemead Adult School
Licensed Vocational Nursing Program-August 2012

Pasadena City College
Associate in Science Degree-November 2010

Student Clinical Experience:

- Santa Anita Convalescent Hospital Temple City, CA
- Baldwin Gardens Convalescent Temple City, CA
- Greater El Monte Community Hospital El Monte, CA

Worked under supervision of a Registered Nurse. Assisted with feeding and bedside care on nursing homes, medical-surgical floors, labor and delivery and pediatric nursing unit. Administer oral medication, dressing changes and all other aspects of nursing care. Organized medical supplies, prepared chart and documentations.

Work Experience:

Western Drug
Glendale, CA
Medical Clerk (January 2009-May 2009)

- Gather information and check eligibility
- Organized medical supplies
- Records and maintains orders
- Demonstrated proper use of supplies to patients and customers

Triune Home Health Provider Inc.
Chino, CA
Medical Clerk (May 2009-Aug 2010)

- Responsible for maintaining the integrity of the medical records of the agencies clients by organizing, assembling, and assessing completeness of client's charts.
- Work closely with billing and clinical staff to ensure proper and timely processing in any of the clients charts.
- Work with computer software to input physician orders, nurse visits, recertification, discharge, and important information regarding patient.
- Ensures patients clinical record completion upon discharged.
- Answers and forwards all telephone inquiries appropriately.

Patient Care Home Health Services
Las Vegas, NV
License Practical Nurse (June 2015-Present)

Certifications:
CPR, LVN

Department of Consumer Affairs

License Details

The Department of Consumer Affairs encourages you to verify the license statuses of any licensees that may appear in a 'Related License' section below. You can verify these licensees by selecting 'New Search' and conducting a new search using the 'Search by Personal or Business Name' option. Please note that the 'Related License' section will only appear below if this license is related to another license. Not all licensees have a related license.

If the License Details below include 'Date of Graduation', the month and date of graduation may not be available. In this instance it will be displayed as '01/01/YYYY' where YYYY represents the year of graduation. Please note that not all license types disclose 'Date of Graduation' on the License Details screen.

Press "Search Results" to return to the Search Results list.

Press "New Search Criteria" to do another search of this type.

Press "New Search" to start a new search.

License Number: 271776 *Current Date: 06/13/2016 04:31 PM*

Name:	VENTENILLA, MYRAH
License Type:	Vocational Nurse
License Status:	Current
Expiration Date:	02/28/2017
Original Issuance Date:	02/13/2013

Disciplinary Actions

There are NO disciplinary actions against the license.

Public Record Actions

Public Documents

None found

Search Results New Search Criteria Print

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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.

Pls see attached!

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
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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 ex

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....

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....

....

ATTACH PH

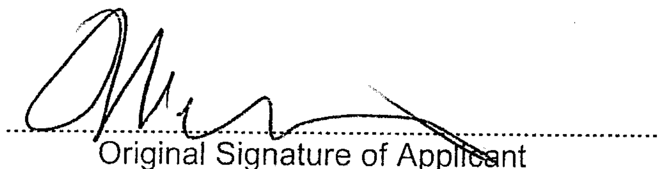
TAKEN W

30 DAYS

Date of photograph 6/3/16

I, Myrah Ventenilla, 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 of 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

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.

☒ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW ________)

☐ Publicly Traded Corporation – Pages 1,2,3,4
☐ Partnership - Pages 1,2,3,6
☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b
☐ 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: Helix Medical Equipment Inc.

Physical Address: 2780 S. Jones Blvd. Las Vegas, NV 89146
(This must be a business address, we can not issue a license to a home address)

Mailing Address: -

City: Las Vegas State: NV Zip Code: 89181

Telephone: ________ Fax: ________

E-mail: ________ Website: HELIXMEDICALEQUIPMENT.COM

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Presently we are not a store front business. See attached letter describing our current business model.

Mon: 9 to 1pm Tue: to Wed: to Thu: to

Fri: to Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Angelo Petrilli and or Deborah Petrilli

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

☐ Medical Gases**
☒ Respiratory Equipment** Small volume nebulizers and accessories
☐ Life-sustaining equipment**
☐ Diabetic Supplies
☐ Assistive Equipment
☐ Parenteral and Enteral Equipment**
☐ Orthotics and Prosethics
Other: To be determined

**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: Angelo Michael Petrilli Telephone: 775 343-2540

93199

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:

N/A in process

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 Name: N/A
- ☐ Advanced Practitioner of Nursing Name: N/A
- ☐ Physician's Assistant Name: N/A
- ☐ Physical Therapist Name: N/A
- ☐ Occupational Therapist Name: N/A
- ☐ Registered Nurse Name: N/A
- ☐ Respiratory Therapist Name: N/A

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

APPLICATION FOR NEVADA MDEG LICENSE

<u>This page must be submitted for all types of ownership.</u>

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.

Angelo Petrilli

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

ANGELO PETRILLI

Print Name of Authorized Person

June 14, 2016

Date

Board Use Only	Received: 10/28/16	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: n/a

Corporation Name: Helix Medical Equipment Inc.

Mailing Address:

City: Las Vegas State: NV Zip: 89131

Telephone: Fax:

Contact Person: Angelo Petrilli

For any corporation non publicly traded, disclose the following:

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

a) Angelo Petrilli
Name Address

b) n/a
Name Address

c)
Name Address

d)
Name Address

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

2) Provide the number of shares issued by the corporation. 1000

3) What was the price paid per share? $5

4) What date did the corporation actually receive the cash assets? June 9, 2016

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

June 10, 2016

Nevada State Board of Pharmacy
431 Plumb Lane
Reno, NV 89509

Dear Board

Helix Medical Equipment ("Helix" or "we")) respectfully requests licensing as a DMEG supplier in Nevada. We would like to commence our retail sales activity in early August 2016.

We are a newly formed company incorporated in Nevada on June 9, 2016. Helix's initial focus as a retail supplier of medical equipment will be on enhancing the health care experience and outcomes of those precious children who, while economically disadvantaged, are being treated by pediatric physicians and other pediatric focused medical service providers who are enrolled with Nevada Medicaid as an Ordering, Prescribing or Referring provider ("OPR")[1] Accordingly, we are in the process of enrolling with Nevada Medicaid and Nevada Check Up (collectively (Medicaid), subject to Board licensing.

Given my extensive experience working as a professional and executive in a regulated industry for over 27 years, I value, welcome and appreciate the regulator's role and the importance of earning your trust and in building a strong working relationship. In this spirit, I thought it would be helpful to provide you with some additional background that I hope will help you better understand (i) our business model (ii) my qualifications to serve as the Administration and (iii) the purpose for our Nevada facility and our publicly posted hours of operation.

Business model

As stated above, our initial focus will be to improve the health care experience and outcomes of children and other consumers who have a medical need for the use of a nebulizer. We will do this by placing our nebulizer products (compressors and accessories) at physician offices for our retail sale to consumers. OPRs will have the option to refer our product to their patients.[1] OPRs have told us that the healthcare experience of the patient, caregivers and the OPR is greatly enhanced when our product can be provided to the patient (our consumer) before he/she leaves the OPR's facility. This occurs because (i) the patient (and his/her caregiver) can immediately interact and get acquainted with our product nearly at the same moment that the OPR determines a medical need for a nebulizer [a potentially disconcerting moment for the patient], (ii) immediate availability at the doctor's office is a great convenience to the caregiver who otherwise would have to find the product on her/his own [and given all the choices out there, may end up with a lower quality or inappropriate product], (iii) the child/patient can start treatment right away rather than waiting [perhaps even a few days] while the caregiver searches for the product elsewhere, (iv) the OPR will instruct the patient and caregiver on how to set up, use, and maintain the product in a way consistent with the product's design while the patient explores and interacts with the product, (v) by allowing the preceding to happen in the doctor's office, the OPR has a unique opportunity to further enhance his/her reputation and relationship with the patient and caregiver and, (vi) because our pediatric compressor/nebulizers are modeled in child

1. Title to the product will be retained by Helix until sold at retail to a consumer. No OPR or his/her employer has any direct or indirect financial interest in Helix, nor receives any remuneration for referring our product to their patients. (NAC 639.6941 1(i).

A.?

friendly shapes such as trains, fire trucks, penguins, puppies other familiar "fun" shapes, the child will be much more eager to try and use it, thereby potentially enhancing the desired medical outcome.

We will initially carry a limited line of products, primarily comprised of compressors for use with a nebulizer and related accessories. As a retailer, we are selling only new products; and do not foresee renting any products to consumers. The retail box for our compressors for use with a nebulizer will include the manufacturer's written information to comply with NAC 639.6954 (2) and (5).

While we are a retailer of DME to consumers, we are not, nor shall we be in the foreseeable future, a store-front business.

None of our products require a prescription by law for it to be sold to consumers. Nonetheless, we will comply with NAC 639.6949 when we sell our products to consumers pursuant to a referral from a POR who has written a prescription or order, or where we have documented a verbal prescription or order.

We believe that our business model, as described above, serves the public interest and complies with the requirements of NAC 639.6946 (1) (a), (b), (c) and (d) and, along with the records that we will maintain, with the communication requirements set forth in NAC 639.6951 and NAC 639.6952.

We will not be providing repair services [NAC 639.6946 (1) (e) (2), (j) and (2)] at our facility, but rather will address such matters by replacing the product from our inventory or by returning the product to the manufacturers for replacement subject to their manufacturer's warranty.

We will not be providing any oxygen or medical gases. [NAC639.6954 (1) (a), (b) , (c), (d), (e), (f); (3), and (4)]. None of our products require calibration [NAC 639.6946 (3)].

We will not be designing, fabricating or manufacturing medical products.

We will not be providing medical or therapy services that require professional licensure or registration.

Facility Administrator Role

As stated earlier and as outlined in my Personal History, I have 27 years of extensive experience as an executive and client serving professional (CPA) in a regulated industry; and I have served clients in numerous industries, including medical equipment, where I advised on business processes and operations. I have spent considerable time understanding all applicable rules and regulations along with the quality standards of MDEG suppliers in Nevada; and we will operate accordingly. I am also Helix's sole shareholder and it's President; and therefore have a direct and substantial interest in ensuring that Helix operates in full compliance with all mandated federal, state and local laws, regulations, rules and standards of care. We will be using HIPPA compliant cloud based applications that will allow me to effectively manage the business on a daily basis irrespective of whether I am physically present at all times at the facility. Customers will be able to reach me directly. I will be on-site often. I believe I am well qualified to serve as the MDEG Administrator for Helix.

My co-Administrator, should the Board deem it necessary, will be Debbie Petrilli, who has 26 years of experience as a registered nurse in various settings (i.e. oncology, medical surgical floor and intensive care). Presently, Debbie provides me with insights related to public health care matters. Debbie is an employee and has no ownership interest in Helix.

Ar

Furthermore, Helix's Manager of POR/Clinic Relationships will be on-site in Nevada. He has been trained by and has worked with another DMEG supplier outside of Nevada who has a similar business model; and within several more months he will have the hours of experience with Helix to also qualify as the Administrator in Nevada. He and I will be communicating daily.

Nevada Facility and Hours of Operation

We will maintain a small (330 sf) office in Las Vegas that will serve primarily as a base for receiving and distributing our products. We may also process customer intake forms and store the physical records of activity with consumers and communications therewith (including complaints) at our Nevada facility, though given our use of HIPPA compliant cloud based applications, we will be able to do the same with respect to these record keeping functions concerning Nevada customers from our facility in Massachusetts. Regardless of where stored, such records shall be readily accessible pursuant to NAC 639.695 through our cloud based HIPPA compliant applications or in physical form, as appropriate. Our Nevada facility will meet the requirements of NAC639.6946 (1) (e), (f), (g), (h) and (i).

Given the primary purpose of our Nevada facility as described above as an inventory receiving and distribution center, and because we are not a store-front retailer, we would like to limit our posted hours of operations with respect to the public to a minimum (say 9am to 1pm on Mondays). This will allow our team to focus on executing on our business model, which requires them to be in the offices of PORs during most regular business hours. Paperwork processing would occur after normal business hours. We will be accessible full time to the public by phone, fax or email; and will respond promptly. Frankly, we anticipate few, if any, visitations to our facility by the public. We believe having the minimum hours posted for public access as previously stated meets the requirements of 639.6946 (4). As we grow, we can expand our public hours of operations as warranted.

I trust the Board will find the above helpful and will allow you to grant Helix Medical Equipment Inc. a DMEG license in time for us to commence sales in early August 2016.

Our desire is to sell to retail consumers through what we believe to be an effective business model that is in the public's interest and that is superior to on-line, mail-order and perhaps even many store-front and HME durable medical equipment retailers already selling similar products to Nevada consumers.

If you have any questions, please call. Your comments and suggestions are welcomed.

Sincerely,

Angelo Petrilli
President
Helix Medical Equipment Inc.

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Confidential

Date May 2, 2016

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 supplier
Nature of License

Helix Medical Equipment Inc. 2780 S. Jones Blvd, Las Vegas NV 89146
Name and Address of Establishment for Which License is Requested

n/a
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
Petrilli	Angelo	N

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

Present Residence Address-Street or RFD	City	State/Zip
	Hanover	MA

Present Business Address	Dates	City	State/Zip
Helix Medical Equipment Inc.	6/8/16	Las Vegas	NV 89131

Occupation	Dates
President	6/8/16

Phone:
Residence
Business

Date of Birth: Pittsburgh, Allegheny, PA

Age	Social Security Number	Sex
56		Male

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Brown	Brown	Caucasion	250	Broad	6'1'

Scars, tattoos or distinguishing marks and/or characteristics n/a

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

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial A.P.

MARITAL INFORMATION-Continued

A. **Current Marriage** .... Monroeville, Allegheny, PA
Date — City, County and State

Spouse's full name (Maiden) Deborah Petrilli (Gunsallus) S.S. No

Date of Birth .... Place of Birth Pittsburgh, PA

Resident address .... Hanover MA
Street — City — State — Zip

Telephone: Residence .... Business ....

Spouse's employer .... Occupation ....

Address of employer ....
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

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 A~

FAMILY INFORMATION-Continued

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

Name n/a

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	Antonio Petrilli	Deceased	Monroeville, PA	Broadcast Engineer
Mother	Maria Petrilli	Deceased	Monroeville, PA	Teacher
Father-in-Law	Lynn Harrison	Deceased	Scottsdale, AZ	Contractor
Mother-in-Law	Darlene Harrison		Scottsdale, AZ	Real estate agent

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
	Anthony Petrilli		Far Hills, NJ	CEO
Spouse	Susan Petrilli (Sach)		Far Hills, NJ	Nurse
	Robert Petrilli		Monroeville, PA	CFO
Spouse	Mary Jane Petrilli (Barrone)		Monroeville, PA	Teacher
	Marco Petrilli		Fort Worth, TX	Teacher
Spouse	Laurie Petrilli		Fort Worth, TX	Flight Attendent
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School				Yes ☒ No ☐
High School				Yes ☒ No ☐
College University	Pennsylvania State University		1978-1982	Yes ☒ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any B.S. Accounting, with distinction

College or university where obtained Pennsylvania State University

Applicant's initial AP

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 ArD

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
Oct. 2001- present(Apr 2016)		Hanover	MA
May 1994 - Oct 2001	10267 N.136th Street	Scottsdale	AZ

Applicant's initial AR

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
Mar 1999 - Jan 2016	Ernst&Young LLP, Boston MA	Retired
Title	**Description of Duties**	**Name of Supervisor**
Executive	Partner / Certified Public Accountant	n/a

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Feb 1999	Great Western Publishing, Phoenix AZ	Sold company
Title	**Description of Duties**	**Name of Supervisor**
CFO	Finance	n/a

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Jul 1996	Self Employed , Scottsdale AZ	Joined Great Western Publishing
Title	**Description of Duties**	**Name of Supervisor**
Consultant	Finanical consulting	n/a

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
May 1993	Bell Sports , Scottsdale AZ	Company restructuring
Title	**Description of Duties**	**Name of Supervisor**
VP Finance	Finance and accounting	n/a

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Jun 1982	Price Waterhouse, Phoenix AZ	New job opportunity
Title	**Description of Duties**	**Name of Supervisor**
Sr.Manager	CPA/ Client service accounting professional	n/a

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 AR

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	Dayton Nordin	Home	Hingham, MA		12
Employer	Ernst&Young LLP	Business	200 Clarendon St. Boston, MA 02116		
Name	Roslyn Guy	Home	Lowell, MA		15
Employer	Ernst&Young LLP	Business	200 Clarendon St. Boston, MA 02116		
Name	Gary Silaci	Home	Lynn, MA		12
Employer	Ernst&Young LLP	Business	200 Clarendon St. Boston, MA		
Name	Debbie Tornabeni	Home	Las Vegas, NV		20
Employer	n/a	Business	n/a		
Name	David MacKinnon	Home	Newton, MA		15
Employer	Ernst&Young LLP	Business	200 Clarendon St. Boston MA 02116		

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

Certified Public Accountant (CPA), MA 16 years

Certified Public Accountant (CPA), AZ 12 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.

Ernst & Young LLP US (as a partner from 1999 to Jan 2016 - retired). I was one of 2,800+ partners in this international, $28billion revenue firm.

The firm's primary regulator in the United States is the Public Accounting Oversight Board (PBAOB); along with the Securities and Exchance Commission ("SEC")

Also subject to numerous standards boards, including the Financial Accounting Standards Board (FASB); and membership in the AICPA and the MA State Board of Accountancy

Applicant's initial [initials]

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

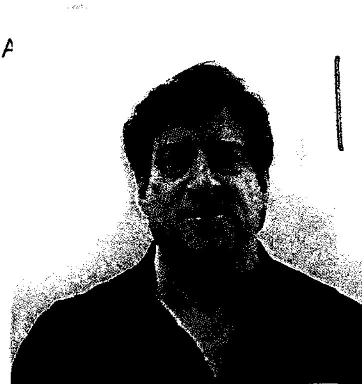
15. Have you ever been refused a business or industry license or related finding of suitability or been a participant in any group which has been denied a business or industry license or related finding of suitability? Yes ☐ No ☒

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 ☒



Date of photograph 6/10/2016

Applicant's initial AND

STATE OF Massachusetts

ss.

COUNTY OF Plymouth

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

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

[signature]

Original Signature of Applicant

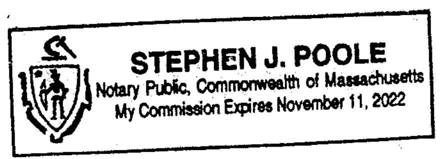
Personal information and personal history has been provided on a confidential basis and is only to be shared with and used by persons with a need to know for purposes of granting a NEVADA DME license / AP

Subscribed and Sworn to before me this 14 day of June, 2016

[signature]

Notary Public

(seal)


STEPHEN J. POOLE
Notary Public, Commonwealth of Massachusetts
My Commission Expires November 11, 2022

Applicant's initial AP

APPLICATION TO BE THE MDEG ADMINISTRATOR 1st

Person who runs the facility on a daily basis

Date June 10, 2016

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 administrator.

Nature of MDEG

Helix Medical Equipment Inc. 2780 S. Jone Blvd. Las Vegas NV 89146

Name and Address of Business for Which MDEG Administrator Is Requested

N/A - Newly formed company in NV

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Petrilli | Angelo | N.
Last Name | First Name | Middle Name

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

Hanover MA
Present Residence Address-Street or RFD | City | State/Zip

Dates | Las Vegas | NV 89131
Present Business Address | City | State/Zip

President / sole shareholder | Dates Since formation on June 8, 2016
Present Position with the MDEG

Phone: ______ Fax: ______

Email address: ______

Pittsburgh, Allegheny, PA
Date of Birth | Place of Birth (City, County, State)

56 | | M
Age | Social Security Number | Sex

Brown | Brown | 250 | 6'1"
Color of Eyes | Color of Hair | Weight | 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.

see attached.

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

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:
b)

State: N/A

Date: ______

Case Number: ______

c) Criminal Action:

State: N/A

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

see attached

A

Date of photograph 6/10/2016

I, Angelo Petrilli, 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 of 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.

Angelo Petrilli
Original Signature of Applicant

Personal information of applicant has been provided on a confidential basis and is only to be used by or shared with persons who have a need to know for purposes of granting a Nevada DMEG license/AP

APPLICATION TO BE THE MDEG ADMINISTRATOR

2nd

Person who runs the facility on a daily basis

Date June 10, 2016

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.

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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 administrator.

Nature of MDEG

Helix Medical Equipment Inc. 2780 S. Jone Blvd. Las Vegas NV 89146

Name and Address of Business for Which MDEG Administrator Is Requested

N/A - Newly formed company in NV

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Petrilli | Deborah | Lynn
Last Name | First Name | Middle Name

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

Hanover | MA
Present Residence Address-Street or RFD | City | State/Zip

5913 Lone Ranch Ave | Dates | Las Vegas | NV 89131
Present Business Address | City | State/Zip

Public Health Advisor | Dates Since formation on June 8, 2016
Present Position with the MDEG

Phone: ______ Fax: ______

Email address: ______

______ | Pittsburgh, Allegheny, PA
Date of Birth | Place of Birth (City, County, State)

54 | ______ | F
Age | Social Security Number | Sex

Brown | Brown | 145 | 5'5"
Color of Eyes | Color of Hair | Weight | Height

Scars, tattoos or distinguishing marks and/or characteristics ______

Are you a citizen of the United States? Yes ☒ No ☐

If alien, registration No n/a

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.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
2004 to 2016	Partners Health Care / Massachusetts General Hospital Fruit Street, Boston MA	1500+

Title	Description of Duties	Name of Supervisor
Registered Nurse	Intensive care unit - patient care	n/a

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
1990 to 2001	Scottsdale Memorial Hospital Shea Blvd, Scottsdale AZ	1500+

Title	Description of Duties	Name of Supervisor
Registered Nurse	Oncology unit, Surgical unit, then Intensive care unit - patient care	n/a

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:
b)

State: N/A

Date: ____________________

Case Number: ____________________

c) Criminal Action:

State: N/A

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 ☒

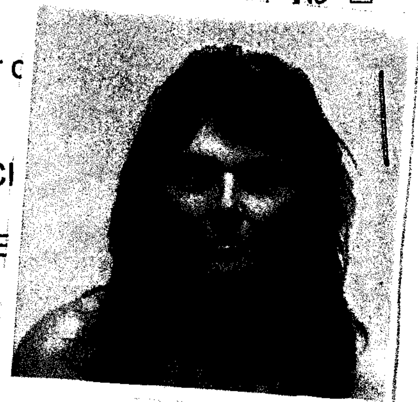
If you answer No to questions 4, 5 or 6 please provide a written letter c

see attached

ATTACI

TAKE

30



Date of photograph 6/10/2016

I, Deborah Petrilli, 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 of 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.

Deborah L Petrilli

Original Signature of Applicant

Personal information of applicant has been provided on a confidential basis and only to be shared with or used by persons who have a need to know for purposes of granting a Nevada DMEG license. / DP

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.

☒ New MDEG ☒ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW ______________)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☒ Partnership - Pages 1,2,3,6
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ 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: EMMANUEL BIABENE Ozomor Medical Supplies INC.

Physical Address: 4481 W. RENO AVE, LAS VEGAS, NV 89118
(This must be a business address, we can not issue a license to a home address)

Mailing Address: SAME AS ABOVE

City: LAS VEGAS State: NV Zip Code: 89118

Telephone: 702 629-6845 Fax: 702 629 5054

E-mail: ______ Website: ______

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9:00 to 5:00 Tue: 9AM to 5PM Wed: 9AM to 5PM Thu: 9AM to 5PM

Fri: 9AM to 5PM Sat: CLOSED Sun: CLOSED Holidays: CLOSED

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: EMMANUEL BIABENE

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

☒ Medical Gases**
☒ Respiratory Equipment**
☐ Life-sustaining equipment**
☐ Diabetic Supplies
☐ Assistive Equipment
☒ Parenteral and Enteral Equipment**
☐ Orthotics and Prosethics
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: EMMANUEL BIABENE Telephone: 702 629 6845

92465

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:

6466110001

1720306889

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	Name:
☒ Advanced Practitioner of Nursing	Name: FESTUS EBONKA
☐ Physician's Assistant	Name:
☐ Physical Therapist	Name:
☐ Occupational Therapist	Name:
☐ Registered Nurse	Name:
☐ 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.

Emmanuel Biabene

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

EMMANUEL BIABENE — 11/20/2015

Print Name of Authorized Person — Date

Board Use Only	Received: 4/12/16	Amount: 500-

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A PARTNERSHIP

List names of 4 largest partners and percentage of ownership:

Name: EMMANUEL BIABENÉ %: 50

Name: FESTUS EBONKA %: 50

Name: N/A %: N/A

Name: N/A %: N/A

Partnership Name: OZOMOR MEDICAL SUPPLIES

Mailing Address: 4481 W. RENO AVE

City: LAS VEGAS State: NV Zip Code: 89118

Telephone Number: 7026296845 Fax Number: 7026295054

Contact Person: EMMANUEL BIABENE

PARTNERSHIP

Include with the application for a partnership

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

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 03/31/2016

GENERAL INSTRUCTIONS

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

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

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

Application for M D E G
Nature of License

OZOMOR MEDICAL SUPPLIES INC, 4481 W. RENO AVE, LAS VEGAS, NV 89118
Name and Address of Establishment for Which License Is Requested

NOT APPLICABLE
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name: BIABENE — First Name: EMMANUEL — Middle Name: MOMATE

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise): BIABENE MOMATÉ EMMANUEL

Present Residence Address-Street or RFD: 4481 W. RENO — Dates — City: LAS VEGAS — State/Zip: NV 89118

Present Business Address — Dates — City — State/Zip: 702 629 6845

Occupation: DIRECTOR OF OPERATION

Phone: Residence

Business

Date of Birth — Place of Birth (City, County, State): GOMA, CONGO-KINSHASA

Age: 39 — Social Security Number — Sex: MALE

Color of Eyes: BROWN — Color of Hair: BLACK — Complexion — Weight: 180 — Build — Height: 5'7"

Scars, tattoos or distinguishing marks and/or characteristics PRESCRIBED GLASSES

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

If naturalized, certificate N Date 01/25/2013

Place US DISTRICT COURT, LAS VEGAS, NV (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial E B

MARITAL INFORMATION-Continued

A. **Current Marriage** ...., Las Vegas, Clark County, Nevada
Date / City, County and State

Spouse's full name (Maiden) PRISCILLA BUNYERE BIABENE S.S. No

Date of Birth 12/24/1984 Place of Birth CONGO - KINSHASA

Resident address 3831 MCGREGOR WAY N.LAS VEGAS NV 89032
Street / City / State / Zip

Telephone: Residence ... Business ..

Spouse's employer EXCALIBUR Occupation GUEST ROOM

Address of employer 3850 S LAS VEGAS LAS VEGAS NV 89109
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	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	

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

Name	Street	City	State	Zip	Telephone
N/A	N/A	N/A	N/A	N/A	N/A
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Residence Address

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 E B

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	MOMA KWASSA	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Mother	ROSALIE KABUO KAPITULA	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Father-in-Law	PROCIS			
Mother-in-Law	CECILE KARUNGO			

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
	MZEE MOMA	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Spouse	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN
	BAGUMA BIABENE	UNKOWNNN	CONGO-KINSHASA	UNKNOWN
Spouse	UNKNOWN	UNKNOWN	CONGO-KINSHASA	UNKNOWN
	REBECCA BIABENE	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Spouse	UNKNOWN	UNKNOWN	CONGO-KINSHASA	UNKNOWN
	MANU BIABENE	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Spouse	UNKNOWN	UNKNOWN	CONGO-KINSHASA	UNKNOWN

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	ÈCOLE PRIMAIRE KARISIMBI	CONGO KINSHASA	7/82 – 9/90	Yes ☑ No ☐
High School	COLLEGE MWANGA	CONGO KINSHASA	7/92 – 10/99	Yes ☑ No ☐
College University	UNIVERSITE LIBRE DES PAYS DES GRANDS LACS	CONGO	5/20 – 7/2004	Yes ☐ No ☑
Other	UNIVERSITY OF PHOENIX		4/10 – 10/12	Yes ☑ No ☐

Type of degree obtained, if any ASSOCIATE DEGREE

College or university where obtained UNIVERSITY OF PHOENIX

Applicant's initial E B

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date
N/A	N/A	N/A	N/A	
	N/A	N/A	N/A	
N/A	N/A	N/A		N/A

Applicant's initial E.B.

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

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

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

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

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

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
11/2014 TO DATE	3831 MCGREGOR WAY	N. LAS VEGAS	NV 89032
11/2010 to 10/2014	2612 INNOVATION CT	N. LAS VEGAS	NV 89031
10/2008-10/2010	810 M STREET	LAS VEGAS	NV 89106
02/2008 -09/2008	2635 LYNNWOOD ST. #310	LAS VEGAS	NV 89104
08/2007-01/2008	710 EAST SAHARA AVE	LAS VEGAS	NV 89104
08/2004-07/2007	KAKUMA CAMP	KAKUMA	KENYA
12/1976 - 07/2004	GOMA	GOMA	CONGO-KINSHASA
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A

Applicant's initial EB

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 / Title	Name/Mailing Address of Employer/Business / Description of Duties	Reason for Leaving / Name of Supervisor
01/2015	OZOMOR MEDICAL SUPPLIES 4481 W.RENO	STILL
DIRECTOR OF OPERATION	ADMINISTRATION & SUPERVISION	
05/2013	LACANADA PEDIATRICS 3006 S. MARYLAND PKWY	POWER STRUGGLE
OFFICE MANAGER	SUPERVISION & ADMINISTRATION	DR ABBAS KINGO
10/2010	TERRIBLE HERBST 3440 W. RUSSEL RD	JOB ENRICHMENT
CASHIER	CASH HANDLING & CUSTOMER CARE	BROOKE
4/2009	USCENSUS BUREAU LAS VEGAS NV	END OF 2010 CENSUS
CREW LEADER	SUPERVISION and DATA ENTRY	DIANE IRELAND
9/2008	CATHOLIC CHARITIES 1501 N LAS VEGAS BLVD	LACK OF JOB PLACEMENT
JOB DEVELOPER	REFUGEES JOB PLACEMENT	LISA LEONE
09/2007	STRATOSPHERE CASINO LAS VEGAS NV	JOB ENRICHMENT
BAR PORTER	ASSIST BARTENDER IN ALL THEIR NEED	LORI WIREACKY
09/2005	IRC KAKUMA HOSPITAL KAKUMA/KENYA	RESETTLEMENT
HOSPITAL ADMINISTRATOR	ADMINISTRATION & SUPERVISION	DR SAMORA OTIENO
02/2002	ORFAP CONGO-KINSHASA	WAR
ASSISTANT GENERAL MANAGER	ADMINISTRATION & SUPERVISION	PROSPER MUGARUKA

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

Applicant's initial E.B.

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 CRAIG CARAWAY	Home 1407 BAREBACK CT, HENDERSON					6 YEARS
Employer CITY OF HENDERSON	Business					
Name DAN VIRKLER	Home 7737 PARAKEET AVE LAS VEGAS					8 YEARS
Employer	Business					
Name JEAN-MARIE BOLA	Home 10506 GLOWING COVE LAS VEGAS					8 YEARS
Employer Sun Coast Casino	Business					
Name BROOKE	Home					2 YEARS
Employer TERRIBLE HERBST	Business					
Name Jeffrey Hanks	Home					7 YEARS
Employer CLARK COUNTY	Business COURT INTERPRETOR'S OFFICE					

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	
VALUABLE DOCUMENTS	WELLS FARGO	LAS VEGAS NV	EMMANUEL BIABENE	
N/A	N/A	NA	N/A	N/A
N/A	N/A	N/A	N/A	N/A

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

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

Yes ☐ No ☒

If yes, state type, where and years held
N/A N/A N/A N/A N/A N/A N/A
N/A N/A N/A N/A N/A
N/A N/A N/A N/A N/A

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

Applicant's initial E B.

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

Date of photograph 03/31/2016

Applicant's initial EB

STATE OF Nevada
ss.
COUNTY OF Clark

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

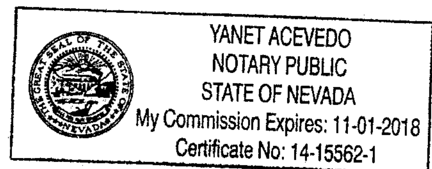
I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and their agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and their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

Emmanuel Biabene

Original Signature of Applicant

Subscribed and Sworn to before me this 7th day of April, 2016

Notary Public



(seal)

Applicant's initial EB