### **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.

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 Tones Blud Suk IC Last Ugas, NV 89/46 (This must be a business address, we can not issue a license to a home address)
Mailing Address: 43) S Dean Markin Dive Sufe 340
City: Las vegs State: NV Zip Code: 89W3
Telephone: 701-237-9984 Fax: 702-834-8490
E-mail: <u>Umadur Medical Ogmail.(om</u> Website:
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 4an to Spm Tue: 9an to Spm Wed: 4an to Spm Thu: 9an to Spm
Mon: 4an to 5pm Tue: 9an to 5pm Wed: 4an to 5pm Thu: 9an to 5pm  Fri: 9an to 5pm Sat: Used to Sun: Clused to Holidays: Clused
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Dongleo Anodor
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: Incontract 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:

Page 1

This	s page must be submitted for all types of	ownership	<u>).</u>	
List	all Medicare and Medicaid provider num	nbers regis	tered to the business c	or its owner:
-		****		<del></del>
1)	Do any shareholders hold an interest any type of business or facility which a or another political jurisdiction?	ownership are license	or have management of by the State of Neva	in da Yes □ No
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?	een associ n MDEG pr	ated with any person, oducts were sold,	Yes ☑ No □
3)	Are any of the owners health profession	onals? If y	es, please check the b	ox and list name.
	<ul> <li>□ Practitioner</li> <li>□ Advanced Practitioner of Nursing</li> <li>□ Physician's Assistant</li> <li>□ Physical Therapist</li> <li>□ Occupational Therapist</li> <li>□ Registered Nurse</li> <li>□ Respiratory Therapist</li> </ul>	Name: _ Name: _ Name: _		

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

This page must be submitted for all types of ownership.

Withir	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 ២
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 🗹
attach	enswer to questions 1 through 5 is "yes", a signed statement of explanation ed. Copies of any documents that identify the circumstance or contain an over disposition may be required.	
l under	y certify that the answers given in this application and attached documentation are stand that any infraction of the laws of the State of Nevada regulating the operation zed MDEG provider or wholesaler may be grounds for the revocation of this permi	on of an
penalty hereby any inv	read all questions, answers and statements and know the contents thereof. I here of perjury, that the information furnished on this application are true, accurate an authorize the Nevada State Board of Pharmacy, its agents, servants and employe estigation(s) of the business, professional, social and moral background, qualification, as it may deem necessary, proper or desirable.	d correct. I ses, to conduct
	al Signature of Person Authorized to Submit Application, no copies or stamp	os
ر Print N	ame of Authorized Person  6-20-16  Date	

Amount: \$500.00

Received: 4 6/38/16

Board Use Only

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.
Owner's Name: Donald Amador
Business Name: A-(/4ss Medical Spplies
Current Business Address: 201 South Dones Blod Suk K
City: Las Vega State: NY Zip: 89146
Telephone: 702-737-9984 Fax: 702-834-8480

## **SOLE OWNER**

# Include with the application for a sole owner

<u>Complete personal history record</u> 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 (1/2) 1/16

#### **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.

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Application for 1	Jurable Medical E Ireal Supplies 20 Medical Supplies	yuipmen Vo	TWNG, U/W of License	ins and	Supplie	<u>u</u>
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A-Class	Medical Supplies	Address of Establishm	ent for Which Licer	ise is Requeste	1	
	lf lf	applicable, Name Unde	r Which It Is Now C	perated		
1. PERSONAL	INFORMATION:					
Amadoa	- SUAREZ	DONAL	, J	(2	ene	
Last Name		First Name			Name	
Alias(es, Nicknames, I	Maiden Name, Other Name	Changes, Legal or Othe	erwise)			
660	Ol Socordo Idress-Street or RFD Jones Blud Sto K	daise C	LAS UCCAS	<del>.</del>	77	89108
Present Residence Ad	dress-Street or RFD	Cit	ty	0.	State/Z	ip
2001 South	Jones Blud Ste K	Dates 02 - 16	o-16 -	Thesent	$N_{\mathcal{U}}$	89146
Present Business Addi	ress	Cit	ty		State/Zi	ip
Occupation	u Milles	Dates 2 - 1 - 11		Dí.	<del></del>	
occupation				Phone: Reside		At Angelog
		MA		Busine:	ss 207	2 724-1734
_ Date of Birth		MANACJA (N Place of Birth (City, Col	icanasua			
_		Flace of Billi (City, Col	unty, State)			; · · · · · · · · · · · · · · · · · · ·
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Color of Eyes	Color of Hair	Complexion	Weight	Build		Height
Scars, tattoos or di	istinguishing marks an	d/or characteristics	**************************************	Ν/Δ		******
re you a citizen o	f the United States?	Yes□ No <b>l</b> 2⁄ If a	alien, registratio	n No		
naturalized, certif	ficate No <i>U∭</i>	<u>}</u>	Date	NIA		
lace	•••••••••••••••••••••••••••••••••••••••		(If natura	lized, docum	ent must	be verified.)
2. MARITAL INF						<b>(</b>
ingle □ Marri	ed □ Separated	□ Divorced 0	₽ Widowed	☐ Enga	ged □	
				Applicant'	s initial	DA
						Pa

MARI	TAL INFORMA						
A.	Current Mari	riage	N/A				
	Spouse's full	name (Maiden)	e		ity, County a S.S. No	and State	
			Place of				
			I				
			C				
	Address of em	ployerStreet		Ci4.	000		
. Pr			parated, divorced, or a			Zip	
		Date of Order					
	f Spouse	or Decree	Date of Place of Marriage	Nature of Action	City Cou	nty and State	
CAD	WARD	17-30-08	12-30-08	mannia		CAS Vegas	
				4			
	Ivaine	Street  Street  SCSC Voo-	elephone numbers of p City tenai st Boise	orevious spouses State 4 13 831 05	Zip	Telephone	
raj:	اللا INFORMA	Street  S2S2 Koo-	City	State  State  State	Zip	g information:	
raji	اللا INFORMA	Street  5252 Koo-  TION: ependents: dren, including step-ch	City  Tenai St Boise  mildren and adopted ch  Birth Place	State  State  State	Zip	g information:	
FAM	HILY INFORMA Children and D List all child Name  hild Support In Please m Please m I am s plan a	TION: ependents: dren, including step-ch Birth Date  nformation: nark the appropriate re subject to a court of subject to a court orde	esponse:	ildren and give the Resi	Zip	g information:	
FAM	hild Support In Please multiple of the	TION: ependents: dren, including step-ch Birth Date  formation: nark the appropriate re subject to a court orde pproved by the distric amount owed pursuar ubject to a court order der or a plan approved	esponse:	ildren and give the Resi child. cor more children and gency enforce or more children and give the public erorder.	n and aming the or	g information: ss in compliance der for the repa	with a aymen

• 1	e child support order:
Name	
Address	
Contact person	
C. Parents:	
List names, residence addresses, dates of birth and most reconserents-	ent occupations of parents, step-parents,
in-law or legal guardian. If retired or deceased, list last addre	
<b>BECOM</b>	Occupation
father	,
LUAN Kene Amadon Annieta N/M Dece	eased Deceased
JUAN RENE AMAJON ANNIETA N/M Dece Mother Convy Manganita Sugnez Espinoza	Km 14 caneters
CONNY MANGANITA SUANCE ESPINOZA	MAGAYA, 600 MASRefined
au lei-lii-Law	restulated Mente
/lother-in-Law	ROSA CASA #27
List names, residence addresses, dates of birth and most rece their respective spouses.  Name (Maiden)  Birth Date  Address	Occupation
CAIRD FURN AMAJOR JUANEZ	Systems Engli
<del></del>	
Glen Amaden : Sasme joy	ct owner of usua
oouse	CI DAPER OF SIDE
TNAN Annden	CI SUPER OF SIGN
pouse	CI SUPER OF SIGN
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TNAN Amadon  Valence Amadon 1444 Monte vista S	
TNAN Amadon  Valence Amadon 1444 Monte vista S	
JALENIA Amadon 1444 Monte vista S	
TNAN Amaden  Douse  VALENA Amaden 1444 Monte vista S  Douse  3. EDUCATION:	theet owner of Amade
TNAN Amaden  Douse  VALENA Amaden 1444 Monte Uista S  Douse  8. EDUCATION:  Name of School Location Dates	Attended Graduate
TNAN Amaden  Douse  VALENA Amaden 1444 Monte Uista S  Douse  8. EDUCATION:  Name of School Location Dates	Attended Graduate
Name of School  Colegio Fame  Colegio Fame  Colegio Sadricta de Micanagua Nicanagua  Colegio Sadricta de Micanagua Nicanagua Nicanagua	Attended Graduate
Name of School  Cologia Fame	Attended Graduate
TNAN Amaden  Valence Amaden 1444 Monte vista S  pouse  4. EDUCATION:  Name of School  Colegio Fance  School  Coleg	Attended Graduate  1995-2001 Yes I'No II  CARAGOR 2001-2006 IN NO II
TNAN Amaden  pouse  VALENIA Amaden 1444 Monte Vista S  pouse  4. EDUCATION:  Name of School Location Dates	Attended Graduate  1995-2001 Yes INO II  CARDYA 2001-2006 IN NO II  Yes INO II

Α	Have you ever se	rved in any armed f	orces?	Yes □ No ⊑	1		
	Branch	MA	Date	of entry-active se	ervice	UA	
	Date of separation	NA	Туре	of discharge		N/A	
		on					
	While in the militan special or general	y service were you court martial? e they occurred-for	ever arrested for Yes □ No □	an offense which	reculted in	Oummon, o	otion - 4.1
В.	Have you registere	ed for the draft?	Yes □ No 🗹				
	County	1K State	NI	Date re	egistered	WA	
6. <i>A</i>	ARRESTS, DETENTION						
Α.	Have you ever bee violation for any rea	n arrested, detained ason whatsoever, re es, give details in sp	d, charged, indicte	ed or summoned	to answer fo	or any crimi	nol efference
Date of		. Charge	Location-City and	State [	Deposition/Date	Arrestin	g Agency
	MA						
-	·						
B.	Has a criminal indic arrested or in which page 10.	you were named a	s an unindicted c	o-party? Yes ⊔	No 🗹 If ye	es. furnish c	details on
C.	Have you ever beer or committee? Yes	1.1 (NO 17					
D.	Have you ever beer commission? Yes	subpoenaed to app	pear or testify bef	ore a federal, sta	ite or county	grand jury,	board or
E.	Have you ever been Yes ☐ No ☐	subpoenaed to tes	tify for any civil, c	riminal or admini	strative proc	eeding or h	nearing?
F.	Have you ever had a	a civil or criminal red	ord expunged or	sealed by a cour	rt order? Yes	s 🗆 No 🗹	<b>Y</b>
G.	If yes, when? Have you ever receif yes when?	ved a pardon or def	erred prosecution	n for any criminal	offense? Ye	S D No F	<b>Y</b>
H.	Has any member of If you answer to any	your family or of you of the above questi	ur spouse's tamir	/ ever been conv	icted of a fol	001/2 V00	□ No □
Name		Relationship		 Charge	Loc	cation	Date
٨	11					Jation	Date
	(IT						
			- 10-				
				Appl	icant's initial	04	

5 MILITARY INFORMATION:

## ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

34		Court and Case					
Claimant/Respondent	Date Filed	Number	City, Cour	nty and State		oisposition/l	<u>Date</u>
N/N							
associated with	al partnership, bus n it as an owner, of lf yes, complete t	siness venture, sole p fficer, director or part he following:	proprietorsh ner) been a	p or closely party to a la	held corporat wsuit, arbitrat	ion (while ion or ba	you were
Name of Entity	-	Type of Entity			oximate Date(s)		
~ (A		Abe of Fluit		Laws	uit/Arbitration/Ba	nkruptcy	
109						·	<u> </u>
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			•				
. RESIDENCES:							
st all residences you h	nave had for the la	st 25 vears:					
nth and Year							
From-To)	Street and I	Number Sello Honizant	City		State or Cou		
1986 - 2007		W-20	MAN	oln wild	ALBENA		<del></del>
2007-2012	7300	Phote cox no	1 Apt	2091	CAS VE	LAS 1	W 89:
12 - 2014	7200	Pinate cove	U	Apt 2111	CAS	Vaca	W 89:
. •	4593	SOCONNO	drive	Los	Vegss	NU	87108
14-2015		Socono	drive	Los	MIAS	M	89108
	6601	1006110	- 1100				$\nu$
	6601	1006110	- 1,04		o cyr,		
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	6601	) 000110	1104				
	6601	) 000110					
	6601	) 000110	1104				
14-2015	6601	) OCONNO	1104		d's initial		

## 8. EMPLOYMENT:

Duties  Medical IIC 4325 Jean 1  Site 340 CV  Address of Employer/Business  ANASE THE BUSINESS  Duties	Reason for Leaving  Glen Amadon
ddroop of Employee/During	Reason for Leaving  Glen Amadon
anage the Business Duties	Glen Amadon
outies 0	
	Name of Supervisor
ddress of Employer/Business	Reason for Leaving
uties	Name of Supervisor
ddress of Employer/Business	Reason for Leaving
uties	Name of Supervisor
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es	Name of Supervisor
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### 9. CHARACTER REFERENCES:

	employer or						
Name	of Where Employed	d Street	City State	Zip	Telephone	Yea	rs Known
Name	Blanca E	steels Home	3846	chtney st	( A5	URSAS NV 891	21/
Employ	ver MGM GM	Business		reall	-		
Name	CLAUNA DAG	Home -	765 Rustic O	desent place	e Hend	enson NJ 80	1011
Employ	er Capital	1 Business	Supervisor	<b>S</b>			
Name	Cynthia Be	LNA Home	6593 5000	no done	CAS Vew	of NU 89108	1:
Employ	er Minage	Hotel Business	Secuntry		7		
Name	Melissa A	ANTAS Home 60	1	Drive La	ts Vegas	NU 89108	1
Employe	er Marayabla	Business	classe (Ass				-
Name	Fermado Si	mencethome 9	1054 MAN	odon Aven	Wet UNIE 7	144 /-	
Employe	er Ahare the	new Business	Bymphy		······································	<del>-</del>	-1 '
3ox Nun		ository? Yes  dete the followin		City and State	Aut	horized Users	
	11111/						
	MH						
11.	the following: Liquor Doctor Accountant Yes  No	Lawyer Contractor Pilot	ed, occupational or Race horse/race Real estate brok Sports promoter	e dog owner ker or salesman	Se Ba	state, including bu curities dealer rber/Cosmetologis ainer or manager	Insurance
	the following: Liquor Doctor Accountant Yes □ No ☑ If yes, state typ	Lawyer Contractor Pilot  oe, where and ye	Race horse/race Real estate brok Sports promoter ears held	e dog owner ker or salesman	Se Ba Tra	curities dealer rber/Cosmetologis	Insurance st Gaming
	the following: Liquor Doctor Accountant Yes □ No ᡚ If yes, state typ	Lawyer Contractor Pilot  oe, where and ye	Race horse/race Real estate brok Sports promoter	e dog owner ker or salesman	Se Ba Tra	curities dealer rber/Cosmetologis	Insurance st Gaming
12.	the following: Liquor Doctor Accountant Yes  No  Iz If yes, state typ  Have you ever interest in a lice If yes, state typ	Lawyer Contractor Pilot De, where and year applied for a city ensed business De, when and whames and address	Race horse/race Real estate brok Sports promoter ears held	e dog owner ker or salesman  business, ventur DE the State of	Se Ba Tra Tra re or industry Nevada? Ye s of the busir	curities dealer rber/Cosmetologis iner or manager increase or held a lesses in which your rbery control or the cost of the cos	Insurance st Gaming Educator
12.	the following: Liquor Doctor Accountant Yes  No  Iz If yes, state typ  Have you ever interest in a lice If yes, state typ involved, the na	Lawyer Contractor Pilot De, where and year applied for a city ensed business De, when and whames and address	Race horse/race Real estate brok Sports promoter ears held  y, county of state bor industry OUTSI ere and give name	e dog owner ker or salesman  business, ventur DE the State of	Se Ba Tra Tra re or industry Nevada? Ye s of the busir	curities dealer rber/Cosmetologis iner or manager increase or held a lesses in which your rbery control or the cost of the cos	Insurance st Gaming Educator
12.	the following: Liquor Doctor Accountant Yes  No  Iz If yes, state typ  Have you ever interest in a lice If yes, state typ involved, the na	Lawyer Contractor Pilot De, where and year applied for a city ensed business De, when and whames and address	Race horse/race Real estate brok Sports promoter ears held  y, county of state bor industry OUTSI ere and give name	e dog owner ker or salesman  business, ventur DE the State of	Se Ba Tra Tra re or industry Nevada? Ye s of the busir	curities dealer rber/Cosmetologis iner or manager increase or held a lesses in which your rbery control or the cost of the cos	Insurance st Gaming Educator
12.	the following: Liquor Doctor Accountant Yes  No  Iz If yes, state typ  Have you ever interest in a lice If yes, state typ involved, the na	Lawyer Contractor Pilot De, where and year applied for a city ensed business De, when and whames and address	Race horse/race Real estate brok Sports promoter ears held  y, county of state bor industry OUTSI ere and give name	e dog owner ker or salesman  business, ventur DE the State of	Se Ba Tra Tra re or industry Nevada? Ye s of the busir responsible	curities dealer rber/Cosmetologis iner or manager increase or held a lesses in which your rbery control or the cost of the cos	Insurance st Gaming Educator  Educator  financial ou were ousiness,

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 1
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  V
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 (1171)
	Applicant's initial $\mathcal{P}^{\mathcal{L}}$

STATE OF NeVada
COUNTY OF CIACK
I. Dead Reve Amaba Sance, 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 filling 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 day of  June 2016  Notary Public  Notary Public  Notary Public  Notary Public  Notary Public  STATE OF NEVADA  County of Clark  A. STEWART  My Appointment Expires Sept. 25, 2016

# APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

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.

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146
••••••

1. PERSONAL INFORM	IATION:		
Amador	Donaldo		Tose
Last Name	First Na	ame	Middle Name
Alias(es, Nicknames, Maio	len Name, Other Name	e Changes, Legal or	Otherwise)
7147 South Durang Present Residence Address	o Drive Apt 109	Las Vegas	MV 84103
Present Residence Addre	ss-Street or RFD	Ćity	State/Zip
Present Business Address	wik 10 Dates 6/2016	las Vegas	NV 89146
Present Business Address	ı	City	State/Zip
Present Position with the	<u>Dates ໃຈ/ ໄນໄໄດ</u> MDEG		
Phone: 70) -	237-9984 F	ax: <u>101-834</u>	1-8490
Email address: _			
Date of Birth	<u>Munahuu</u> Place of Birth (	<i>, Ni Coraguo</i> , City, County, State)	
34			Male
Age	Social Security	Number	Sex
$\frac{Brown}{Color \text{ of Eyes}}$ $\frac{B/a}{Color}$	<u>ck</u> of Hair W	235 /eight	<u>\$'//</u> Height
Scars, tattoos or distinguis	hing marks and/or cha	racteristics <u>Table</u>	oos on left shoulde
and am. Also Jahr	o on lower rig	ht leg	
Are you a citizen of the Un	ited States? Yes ⊠Ń	o. 🗆	
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/	Amadu Medical 43X Degn Mohn Drive Sto Name/ Address of Employer/Business	340 4,000
Month and Year '	Name/ Address of Employer/Business	No of Employed Hours
Business Development Ma	Description of Duties	Donald Amader
Litle	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
•		, . <b>,</b>
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 Early
weath and Four	Name: Address of Employer/business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
		Tame of Supervisor
Month and Year	Name / Add - CE - L	
Month and Teal	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
	and the state of t	Name of Supervisor
Month		
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of C
	2 330 iption of buttes	Name of Supervisor

I have ☐ I have not ☐ been diagno or a physical condition that would impair my license, including alcohol or substance abus	ability to perform any of the essen	for a mental illness tial functions of my
1. I have □ I have not □ been charge	ed, arrested or convicted of a felony	y or misdemeanor.
2. I have □ I have not □ been the su pending.	bject of an administrative action wh	nether completed or
<ol> <li>I have □ I have not □ had a licens disciplined, including any action again</li> </ol>		
If you checked "I have" to questions 1, 2 and provide a written explanation and/or docume		information <u>and</u>
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 a operation of the MDEG?		Yes ☑ No □
5 .Will you be employed fulltime with the	e MDEG?	Yes  No □
6 .Will you be present at the site of the during its normal operating hours?	MDEG	Yes ☑ No □
If you answer No to questions 4, 5 or 6 pleas	se provide a wri	
	Date of photograph (i)	2012/10

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. LAT VEGAT, NV £91, (This must be a business address, we can not issue a license to a home address)
(This must be a business address, we can not issue a license to a home address)
Mailing Address: 2475 S. Jones BLVO.
City: LAS VEGAS State: NEVADA Zip Code: 89146
Telephone: 702 4833650 Fax: 702/4833325
E-mail: Website:
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 9:00 pt Tue: 9 AM to Spr Wed: 9 ary to Spr Thu: 9 am to Spr
Fri: 9 My 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** ☐ Assistive Equipment
Respiratory Equipment**  Parenteral and Enteral Equipment**
☑ Life-sustaining equipment**          Orthotics and Prosethics
Diabetic Supplies 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: Telephone: 702-427-1719
Town Partick W. Page 1
JOHN PATRICK W. Page 1 DELA ROSA

This	page must be submitted for all types of	ownership. N/A Initial Ci	to a ter
List	all Medicare and Medicaid provider numl		
·,			
1)	Do any shareholders hold an interest of any type of business or facility which a or another political jurisdiction?	ownership or have management in are licensed by the State of Nevada	Yes 🗆 No 🔎
2)	Are you or have you in the last year be business or health care entity in which		
	dispensed or distributed?		Yes □ No Ø
3)	Are any of the owners health professio	nals? 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:	

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

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 Ø
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 □
attach	answer to questions 1 through 5 is "yes", a signed statement of explanation ed. Copies of any documents that identify the circumstance or contain an over disposition may be required.	
I under	by certify that the answers given in this application and attached documentation are rstand that any infraction of the laws of the State of Nevada regulating the operati ized MDEG provider or wholesaler may be grounds for the revocation of this perm	ion of an
penalty hereby any inv	read all questions, answers and statements and know the contents thereof. I here of perjury, that the information furnished on this application are true, accurate an authorize the Nevada State Board of Pharmacy, its agents, servants and employ vestigation(s) of the business, professional, social and moral background, qualification, as it may deem necessary, proper or desirable.	nd correct. I vees, to conduct
Origin	at Signature of Person Authorized to Submit Application, no copies or stam	ps
	Vame of Authorized Person    The contract   The con	
Board	Use Only Received: 678/16 Amount: \$500.00	)

# OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

Parent Company if any:    Mailing Address:
<ol> <li>List top 4 persons to whom the shares were issued by the corporation?</li> </ol>
in the second by the corporation:
a) JOHN PATRICK W. DE LA DISA 8877 Waltzing Water ct. LAS VEENS) Name Address
b)
Name Address
c)
Name Address
d)
Name Address
<u>NOTE:</u> 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 <i>documents for all types of businesses</i> .
2) Provide the number of shares issued by the corporation
3) What was the price paid per share?
4) What date did the corporation actually receive the cash assets? 4/10/s
5) Provide a copy of the corporation's stock register evidencing the above information

# PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date /2/18/15

### **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.

Withdrawn Withou	( the permission of the		nicy.	Famile	on	ent		
Application for	Medico	y suppa	ls T			·····		
All MEDIC	CAL "R"US .	24 ZT S Si	snes Bi	SPE.	4	LAS V	regal , 1	10 891
	Name ar	nd Address of Esta	blishment for	Which Licens	e is Re	equested	V	
		If applicable, Name	e Under Whic	h It Is Now Op	perated	· · · · · · · · · · · · · · · · · · ·		
1. PERSONAL NELA ROS	INFORMATION:	John	1 Potric	ck –		WEB	STER	
Last Name			Name			Middle Nar		
Alias(es, Nicknames,	Maiden Name, Other Nam	e Changes, Legal	or Otherwise)					
	,				-	Л	EVADA	
Present Residence Ad	112ing WCTERS ddress-Street or RFD	? <u></u>	City	70 71.3			State/Zip	
2475 J							•	Ha
Present Business Add		Dates 2	City	. 177	•		<i>VV 8914</i> State/Zip	7
			,				·	
Occupation		Dates			-	Phone:		
						Residence		
,						Business	702 4	7 3 3 6 5
Date of Birth		Place of Birth (0	City, County, S	State)			· · · · · · · · · · · · · · · · · · ·	
22			-				ma	eli
Age	Social S	Security Number					Sex	
Brown	Block			171 16	<b>)</b> \$.		5	19
Color of Eyes	Color of Hair	Complexion		Weight		Build	Heig	
Scars tattoos or o	distinguishing marks	and/or characte	eristics	None	—— ン			
Are you a citizen	of the United States?	Yes 🗹 No 🛭	☐ If alien,	, registratio	n No			
lf naturalized, cer	tificate No			_Date				
Place				(If natura	ilized,	documen	t must be v	erified.)
2. MARITAL IN								
/								
Single 🗹 Mai	rried 🗆 Separate	d 🗆 Divor	ced 🗆	Widowed		Engage	d 🗆	
					Δr	plicant's i	nitial	J.D.
					, .h	, priodrit o i	,	

٨.	Current Marriage				
	Spouse's full name (Maiden)			City, County an	d State
	Date of Birth	i 1 / /1			
	Resident address				
			City	State	∠ıp
	Telephone: Residence				
	Spouse's employer				
	Address of employerStreet		City	State	7in
B. F	Previous Marriages: If ever legally s				Ζip
	Date of Order	Date of Place	Nature o		
<u>ame</u>	of Spouse or Decree	of Marriage	Action		ty and State
	List of names, current address and Name Street	telephone numbers of City	State	Zip	Telephone
	MILY INFORMATION: Children and Dependents:	City	State	Zip	
_	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date	City	State  children and give	Zip	information:
F.A.	MILY INFORMATION: Children and Dependents: List all children, including step-	City  Children and adopted	State  children and give	Zip	information:
	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date	City  Children and adopted	State  children and give	Zip	information:
	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date	City  Children and adopted	State  children and give	Zip	information:
	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date	City children and adopted Birth Place	State  children and give	Zip	information:
<b>1.</b>	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date  WWWE  Child Support Information:	children and adopted Birth Place	children and give	Zip	information:
<b>1.</b>	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date  WWWE  Child Support Information: Please mark the appropriate	children and adopted Birth Place  response: rt order for the support of a crict attorney or other responses.	children and give	e the following	1 information:
<b>1.</b>	MILY INFORMATION: Children and Dependents: List all children, including step- Name Birth Date WWW  Child Support Information: Please mark the appropriate I am not subject to a court on plan approved by the dist	children and adopted Birth Place  response:  rt order for the support of crict attorney or other puant to the order; or der for the support of crict attorney or other puant to the order; or der for the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the support of crict by the district attorney or other puant to the crick by the district by the distric	children and give R t of child. One or more child One or more child	the following esidence Address liven and am in ording the ordinates and NOT	n compliance with

FAMIL	LY INFORMATION-Continued  District attorney or public agency response	rible for enforcing the child support	tordor: 4//
	Name		/*/
	Address		
c.	Contact person Parents:		
parent	List names, residence addresses, dates of ts-	of birth and most recent occupation	ns of parents, step-parents,
	in-law or legal guardian. If retired or dece Name (Maiden) Birth Date	eased, list last address and occupa Address	Occupation.
	Harro (Haldori) Birth Date	Addiess	Occupation
Father	nation Arian aura in	' 8877 Waltzing	waters 9. Desirereman
Mother	OPENO DELA ROSA JR	· LV NV 891	47 - +151-1711
	PABETH DELA ROSA -	- 5877 Waltzing	Waters of granefeman Waters of Office mana
Mother-i	-in-Law		
D.	Brothers and Sisters: List names, residence addresses, dates of their respective spouses.		
1/1	Name (Maiden) Birth Date	Address	Occupation (
	RIANNE DELA ROSA-	1 8877 Waltzing Wood	- marketing
Spouse V	an HUANG	- Same	- Compuler
M	ORENOW DELA ROSA TIL-	877 waltzing w	ater of part-time office
Spouse		20 20 8716	ty Cterk
 Spouse			
Spouse			
4. EC	DUCATION:		
***************************************	Name of School L	ocation Dates Attended	Graduate
Gramma School	ar Eagle Canyon, Arrow Monfesso	ri CA . 1998-2000, 201	00-2006 Yes No []
High School	Ayafa High School, Buena Vista.	High School CA. 2007 - 26	90, 2011 Yes No [
College Universit	Name of School  Lar Ecrefe Carryon, Arrow Monfesson Ayasa High School, Brena Vista  CSW  Community College  of degree obtained, if any  Still in the	45 Vegas Currently	Yes □ No
Other	community College	Jaking 23/1	ega Coarsifes   No 1
Type of	of degree obtained, if any Still in 1	re process of getting A	As degree in Automotive
College	e or university where obtained Current	ly in CSN college	
Jonege	c of university where obtained	<u> </u>	

## Have you ever served in any armed forces? Yes □ No 12 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? $\nearrow$ Yes $\square$ No $\square$ regardless of where they occurred-foreign or domestic.) Yes $\ \square$ No $\ \square$ If yes, furnish details on page 10. (List all incidents B. Have you registered for the draft? Yes □ No M County\_\_\_\_\_\_Date registered\_\_\_\_\_ 6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.) 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 Has a criminal indictment, information or complaint ever been returned against you, but for which you were not B. arrested or in which you were named as an unindicted co-party? Yes V No 🗀 If yes. furnish details on page 10. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission C. or committee? Yes □ No 凹 Have you ever been subpoegaed to appear or testify before a federal, state or county grand jury, board or D. commission? Yes □ No ☑ Have you ever, been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? E. Yes □ No M Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☑ F. If yes, when? \_\_\_\_\_city, county and state \_\_\_\_\_Have you ever received a pardon or deferred prosecution for any criminal offense? Yes □ No □ G. Η. If you answer to any of the above questions (B through H) is yes, furnish details on page 10. Name Relationship Charge Location Date

5 MILITARY INFORMATION:

Applicant's initial J.D.

# ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

If yes, give det	ans below.		·				
ntiff/Defendant or imant/Respondent	Date Filed	Court and Numb		City, County an	d State	Disposition/	Date
J. Has any gener associated witl Yes □ No ௴	it as an ov	vner, officer, o	director or partne	prietorship or r) been a par	closely held ty to a lawsu	d corporation (whiluit, arbitration or b	le you were ankruptcy?
Name of Entity		Type of E	=ntity			ate Date(s) of arbitration/Bankruptcy	administrative (from the first of the first
Traine or Linky		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			- TTOTAS		
						*****	
			· · · · · · · · · · · · · · · · · · ·				
RESIDENCES:							
	have had fo	or the last 25 v	years:				
all residences you	have had fo	or the last 25 y	years:	·			14/15
RESIDENCES: t all residences you th and Year From-To)		or the last 25 y		City		State or County	
th and Year	St	reet and Number			VEFAS		<i>F9117</i>
t all residences you th and Year From-To)	St	reet and Number			VEEAS VEGAS		89117 89117
th and Year rom-To)  7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
th and Year	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
all residences you th and Year rom-To)  // > Pres 7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
th and Year from-To)  7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
th and Year from-To)  7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
th and Year From-To)  7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
all residences you th and Year rom-To)  // > Pres 7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
th and Year From-To)  7/2011 - 11/-	St rev 80 2011	reet and Number	Mountain Ro	d. LAS		, NEVADA	
all residences you th and Year rom-To)  // > Pres 7/2011 - 11/-	St rev 80 2011	reet and Number	MOUNTAIN RO	d. LAS		, NEVADA	
th and Year from-To)  7/2011 - 11/-	St rev 80 2011	reet and Number	MOUNTAIN RO	d. LAS		, NEVADA	
all residences you th and Year rom-To)  //> //> //> //// ///////////////////	St rev 80 2011	reet and Number	MOUNTAIN RO	d. LAS		, NEVADA	
all residences you hand Year rom-To)  / You - Pres	St rev 80 2011	reet and Number	MOUNTAIN RO	d. LAS		, NEVADA	

## 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 - Pres	Description of Duties  Almi. Filing, Posting,	
Title	Description of Duties	Name of Supervisor
DOTA ENTRE	Alfast. Filing, Posting,	Connie Oliveros
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2012	GAP	reason to Leaving
Title	Description of Duties	Name of Supervisor
Sales	Cashier/Customer Sorvices	
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
itle	Description of Duties	Name of Supervisor
onth and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
itle	Description of Duties	Name of Supervisor
onth and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
tle	Description of Duties	Name of Supervisor

lf

Applicant's initial_	3.0,
	Page 6

## 9. CHARACTER REFERENCES:

	List five charac	cter reference v	who have k	now you	u five years or r	more. Do not include	e relatives, p	resent
Name o	of Where Employed	Street	City	State	Zip	Telephone	Years	Known
Name	chande tai	ng Home M	ont clair	CA.	91763			8
Employ	ver Vape Conn							
Name			Colton	CA	92324			ン
Employ	ver Falcon Abra	Business	ctaring					
Name	Eugene Ad	do Home	Washingt	on D	C	<u> </u>	S	}
Employ	er- primary Co	echate Ye Business						
Name_		Home						
Employ	ег	Business						
Name		Home		**				
Employ	er	Business						
10.	Do you have ar person's depos If yes, complete	itory? Yes 🗀	No 🖆	er such	depository, acc	cess to any depositor	y or do you	use any other
3ox Nur	mber or Type of Depo	sitory	Location		City and State	Authorized U	sers	
11.	Liquor	Lawyer Contractor Pilot	Race ho Real esta Sports p	rse/race ate brok	e dog owner ker or salesmar	cense in any state, in Securities Barber/Cos Trainer or i	dealer smetologist	not limited to Insurance Gaming Educator
12.	Interest in a licer	nsed business e, when and wh mes and addre	or industry iere and giv	OUTSI e name	DE the State of es and location:	re or industry license f Nevada? Yes □ N s of the businesses i responsible for licen	lo 🖅 n which you	Were
						Applicant's init	al JiD	

Page 7

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 ficense, 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 M					
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  V					
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  No					
······						
	Date of photograph 6/2/16					
	Applicant's initial $\mathcal{J} \cdot \mathcal{D}^{2}$					

STATE OF Nevada	
S	S.
COUNTY OF Clark	
, JOHN PATRICK W. DELAROSA	, 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;	
misrepresentation or failure to reveal information requested r	_
a manufacturer license; that I am voluntarily submitting this a	
Statutes 639.210 (10) provides denial or revocation of the ap	_
registration or permit if the holder or applicant "Has obtained	
of an application, or any record, affidavit or other information	· · · · · ·
further, that I have familiarized myself with the contents of Ne	evada Statutes on Pharmacists and Manufacturer and the
Controlled Substances Act, as amended, and the Regulation	s of the Nevada State Board of Manufacturer as
promulgated thereunder and agree, if licensed, to abide there	eby,
I hereby expressly waive, release and forever discha	rge the State of Nevada, the licensing agency and their
agents from any and all manner of action and causes of action	on whatsoever which I, my administrators or executors
can, shall or may have against the State of Nevada, the licen	sing agency and their agents, as a result of my applying
for a manufacturer license in the State of Nevada.	
	(190)
······	Original Signature of Applicant
Subscribed and Sworn to before me this $18^{+}$ day	of survey of the second of the
Decemenber 2015	NOTARY PUBLIC STATE OF NEVADA
Λ <u>-</u> 1	County of Clark
(mode weret	No: 12-8628-1 TYRONDA WEINERT My Appointment Expires Aug. 8, 2016
Notary Public	Andreamannamannaman.

Applicant's initial 5.D. Page 9

(seal)

#### APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

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	T. 4. 1 T. T.	10/0/-
7	∨′Data	12/18/16
	22 Date	/ / // 4 // 4
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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	4 6	EQUIPMENT	
ALC ME	DICAL"R" US	ature of MDEG			
Name	and Address of Business	for Which MDEG	Admir	nistrator Is Requested	
	If applicable Name	Under Which It Is	Nigur		

1. PERSONAI	L INFORMATION	:			
Ventenilla	ો	Myrah		Mo	9120
Last Name		First Name		Middle Na	me
				<del></del>	
Alias(es, Nickna	ımes, Maiden Nar	ne, Other Name Ch	anges, Legal or C	Otherwise)	
10201 A	sti place		LUS Vegas City	M	89134
Present Resider	nce Address-Stree	et or RFD	City	Sta	te/Zip
		Dates			
Present Busines	ss Address		City	Sta	te/Zip
		Dates			
Present Position	with the MDEG				W. W
Phone:		Fax:			
Email address:		,			
Linaii addiess.	<del></del>	1 Of Amantas (			
Date of Birth	<del></del>	LOS Angeles, (			
		Place of Birth (City	, County, State)	e,	
28				<u>t</u>	
Age		Social Security Nur	mber	Sex	
PLOMU	PUMN	130		5'5"	
Color of Eyes	Color of Hair	Weig	ht	Height	
Scars, tattoos or	distinguishing ma	arks and/or charact	eristics		
Are you a citizen	of the United Sta	tes? Yes ズNo □		•	
If alien, registrati	on No				
If naturalized, ce	rtificate No		_ Date		
					So formou,

# 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)

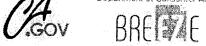
- Responsible for maintaining the integrity of the medical records of the agencies clients by organizing, assembling, and assessing completeness of client's charts.
- Work closely with billing and clinical staff to ensure proper and timely processing in any of the clients charts.
- Work with computer 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)

<u>Certifications:</u>

CPR, LVN

Department of Consumer Affairs



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Current Date: 06/13/2016 04:31 PM

#### 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

VENTENILLA, MYRAH

License Type:

Name:

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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https://www.breeze.ca.gov/datamart/detailsCADCA\_do?coloator=foloa@==1

## **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
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
Γitle	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
itle	Description of Duties	Name of Supervisor

or a physical condition that would impair my a license, including alcohol or substance abuse	ability to perform any of the essent	
1. I have □ I have not  been charge	d, arrested or convicted of a felony	or misdemeanor.
<ol> <li>I have ☐ I have not ☐ been the subpending.</li> </ol>	pject of an administrative action who	ether completed or
<ol> <li>I have ☐ I have not☐ had a license disciplined, including any action again</li> </ol>	e suspended, revoked, surrendered st a professional license that was r	d or otherwise not made public.
If you checked "I have" to questions 1, 2 and provide a written explanation and/or document	or 3, please include the following ints.	nformation <u>and</u>
<ul><li>a) Board Administrative Action:</li><li>b)</li></ul>	State:	
U)	Date:	
	Case Number:	
c) Criminal Action:	State:	
	Date:	
	Case Number:	
	County:	
	Court:	
4. Will you be actively involved in and avoperation of the MDEG?	ware of the daily	Yes į⊠ No ⊡
5 .Will you be employed fulltime with the	MDEG?	Yes 🛮 No 🗆
6 .Will you be present at the site of the A during its normal operating hours?	MDEG	Yes⊮ No □
f you answer No to questions 4, 5 or 6 please	e provide a written letter of ex	
	ATTAÇH PH	
	TAKEN W	
······································	30 DAY\$	
	Date of photograph	0/3/16

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							
NameAigelo i etilii and of Deporari i etilii							
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)							
☐ Medical Gases** ☐ Assistive Equipment							
Respiratory Equipment**  — Parenteral and Enteral Equipment**  — Orthodics and Proportion							
☐ Life-sustaining equipment** ☐ Orthotics and Prosethics							
☐ Diabetic Supplies Other:							
**If providing these types of services you are required to have in place a mechanism to ensure							
continued care in the event of an emergency. Provide name and telephone number of Nevada							
contact. Name: Angelo Michael Petrilli Telephone: 775 343-2540							

Page 1

This page must be submitted for all types of ownership.

List a	II Medicare and Medicaid provider numb	ers registe	red to the business or	its owner	:
N/.	A in process	: 			
<del></del>		······································		<u></u>	
4)					
1)	Do any shareholders hold an interest of any type of business or facility which a or another political jurisdiction?	•	_		<b>N</b> o ⊠
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?			Yes □	No 🗵
3)	Are any of the owners health professio	nals? If ye	s, please check the bo	ox and list	name.
	<ul> <li>□ Practitioner</li> <li>□ Advanced Practitioner of Nursing</li> <li>□ Physician's Assistant</li> <li>□ Physical Therapist</li> <li>□ Occupational Therapist</li> <li>□ Registered Nurse</li> <li>□ Respiratory Therapist</li> </ul>	Name: _ Name: _ Name: _ Name: _ Name: _ Name: _			

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

This page must be submitted for all types of ownership.

Within the last five (5)
--------------------------

Boar	d Use Only Received: 10/28/14 Amount: \$500.0	(W)
	Name of Authorized Person Date	
	GELO PETRILLI	
Origi	nal Signature of Person Authorized to Submit Application, no copies or star	mps
	Anch ~ Petul	
hereb	y authorize the Nevada State Board of Pharmacy, its agents, servants and employeestigation(s) of the business, professional, social and moral background, qualification, as it may deem necessary, proper or desirable.	lyees, to conduct
nonal	e read all questions, answers and statements and know the contents thereof. I he ty of perjury, that the information furnished on this application are true, accurate a	and correct.
Lunde	by certify that the answers given in this application and attached documentation a erstand that any infraction of the laws of the State of Nevada regulating the opera rized MDEG provider or wholesaler may be grounds for the revocation of this pen	LION OF AN
attacl	answer to questions 1 through 5 is "yes", a signed statement of explanationed. Copies of any documents that identify the circumstance or contain an er disposition may be required.	n must be order, agreement,
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 ☒
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 ☑
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 図
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 ☑
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 ☑
	. , ,	

# OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State	e of Incorporation: Nev	<i>y</i> ada	
Pare	nt Company if any: ಗ	la	
Corp	oration Name: Helix Medic	al Equipment Inc.	
			Zip: 89131
Telep	phone:	Fax:	
	act Person: Angelo Petrilli		
For a	ny corporation non publicly	traded, disclose the follow	ving:
1)	List top 4 persons to whom	the shares were issued l	by the corporation?
	a) Angelo Petrilli Name	Address	
	b)/ الإ		·
	Name	Address	
	C)Name	Address	
	d)	25.	
	Name	Address	
recor	E: All persons who are sto d form. Download the form vailable under the document	from the website under th	tely complete a personal history e "New Applications" tab. The forms ees.
2)	Provide the number of shar	res issued by the corporate	tion
3)	What was the price paid pe	er share?\$5	
4)	What date did the corporati	ion actually receive the ca	ash assets?June 9, 2016
5)	Provide a copy of the corpo	oration's stock register evi	idencing 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")<sup>1</sup> 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. 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

<sup>1.</sup> 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).

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 <u>selling only new</u> 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 <u>are not</u>, 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 <u>will not</u> 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 <u>will not</u> 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.

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,

Ample - Pathell

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		M	DEG su	pplier				
Helix N	ledical Equipment	Inc. 2780 S	ure of Lice <b>. Jones</b>	<sup>nse</sup> Blvd, Las	Vega	is NV 89146	)	
	Name and	Address of Establis	shment for	Which Licens	se Is R	equested		
	lf :	applicable, Name U	<b>/a</b> Inder Whic	ch It Is Now O	perated	d		•••••
1. PERSONAL INI Petrilli	FORMATION:	Ange	elo			N		
Last Name		First Na				Middle Name		
Alias(es, Nicknames, Mai	den Name, Other Name	Changes, Legal or	Otherwise	)		, , , , , , , , , , , , , , , , , , ,		
	<b>.</b>		Hanove	er			MA	
Present Residence Addre	ss-Street or RFD		City				e/Zip	
Helix Medical E		Dates 6/8/16	Las Ve	egas			/ 8913	1
Present Business Addres President	S	Deta 6/8/16	City			Stat	e/Zip	
Occupation		Dates 0/0/10	,,,,,,,,,,,,,	· · · · · · · · · · · · · · · · · · ·		Phone: Residence		
		Pittsburgh, Alle	eahenv.	PA		Business		:
Date of Birth	· · · · · · · · · · · · · · · · · · ·		- 3,					
56								Male
Age	Social Se	curity Number	·····			· · · · · · · · · · · · · · · · · · ·	Sex	<u></u>
Brown	Brown	Caucasion		250		Broad	6'1	1
Color of Eyes	Color of Hair	Complexion		Weight		Build	Heigh	t
Scars, tattoos or dist	inguishing marks ar							
Are you a citizen of t	he United States?	Yes⊠, No⊡	If alien	, registratio	n No	~~~~~~~		
lf naturalized, certific	ate No			_Date		****************	***********	
Place				(If natura	lized,	document m	ust be ve	rified.)
2. MARITAL INFO	RMATION:							
Single □ Marrie	d 🗓 Separated	□ Divorce	d 🗆	Widowed		Engaged		
					Αŗ	pplicant's initi	al A	ج

### MARITAL INFORMATION-Continued

Current Mar	riane		Mo	nroeville, A	llegheny, PA
Quirent mar	Dat	e borah Petrilli (ほっょなんしら)	City, C	ounty and Sta	ta
Date of Birth		Place of Birth_	Pittsburgh, I		•
Resident add	dress	Hanover Cit	M	Α	
	Street	Cit	y St	ate Zip	
Telephone:	Residence	Busine	ess		
Spouse's em	nployer	Occup	ation		
Address of e	employer	Cit			
	Street	Cit	y St	ate Zip	
Previous Marri	ages: If ever legally se	eparated, divorced, or annulle	ed, indicate bel	ow:	-
	Date of Order	Date of Place	Nature of	City	
me of Spouse	or Decree	of Marriage	Action	County a	and State
n/a					
		telephone numbers of previ	ous spouses: State	Zip	Telephone
<u>Nam</u>	e Street	City	State	<u> </u>	relephone
n/a					
<u> </u>					
. FAMILY INFOR	RMATION:				
A. Children ar	nd Dependents:				
		o-children and adopted childr Birth Place	en and give the	<u>e following li</u> lence Address	nformation:
Nam	ie <u>Birth Date</u>	DIIII Flace	TXCOIC	ionico madroco	
				-	
		•		`	
		i			
	oort Information: ase mark the appropria	ite response:			
₽	I am not subject to a co	ourt order for the support of c	hild.		
• • • • • • • • • • • • • • • • • • • •				n and am in	compliance with
	I am subject to a court plan approved by the d of the amount owed pu	order for the support of one of istrict attorney or other public rsuant to the order; or	c agency enfor	cing the ord	er for the repayme
	I am subject to a court	order for the support of one	or more childre	n and NOT	in compliance with
	the order or a plan app	roved by the district attorney	ordor		_
	the repayment of the a	mount owed pursuant to the	oruer. Applica	nt's initial	A~)
			, , , , , , , , , , , , , , , ,		Pag

	iouroc autorricy or public a	gency responsit	ole for enforcing the child support of	order:
A	ddress			
			·	
C. Pa	arents:		birth and most recent occupations	
arents-				
	-iaw or iegai guardian. If Ime (Maiden)	retired or decea Birth Date	sed. list last address and occupati Address	On. Occupation
ather				
	tonio Detrilli	Danasad	Advisor of Mills DA	
An fother	tonio Petrilli	Deceased	Monroeville, PA	Broadcast Engine
Mi	aria Petrilli	Deceased	Monroeville, PA	Teacher
ather-in-Lav	v			
Ly	nn Harrison	Deceased	Scottsdale, AZ	Contractor
other-in-Lav	W			
D	arlene Harrison		Scottsdale, AZ	Real estate agent
the	eir respective spouses. me (Maiden)	Birth Date	birth and most recent occupations  Address	Occupation
Anthor	ny Petrilli		Far Hills, NJ	CEO
oouse	n Petrilli (Sach)	•	Far Hills, NJ	Nurse
Robert	Petrilli		Monroeville, PA	CFO
oouse Mary	Jane Petrilli (Barrone)		Monroeville, PA	Teacher
Marco	Petrilli		Fort Worth, TX	Teacher
oouse Laurie	e Petrilli		Fort Worth, TX	Flight Attende
oouse			· · · · · · · · · · · · · · · · · · ·	
4. EDUC	ATION:			
	ATION: Name of School	L∞	ation Dates Attended	Graduate
ammar hool		Loc	ation Dates Attended	Graduate Yes ⊠ No □
ammar hool jh		Lœ	ation Dates Attended	Yes X No □
ammar			ation Dates Attended  1978-1982	
ammar hool gh hool llege	Name of School			Yes ⊠ No ☐
ammar hool gh hool llege iversity	Name of School	University		Yes <b>⊠</b> No □ Yes <b>顷</b> No □ Yes <b>顷</b> No □

## 5 MILITARY INFORMATION: Yes □ No 🔯 Have you ever served in any armed forces? A. 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 Yes □ No □ If yes, furnish details on page 10. (List all incidents special or general court martial? regardless of where they occurred-foreign or domestic.) Have you registered for the draft? Yes □ No 🗓 B. County\_\_\_\_\_\_Date registered\_\_\_\_\_ 6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.) Have you ever been arrested, detained, charged, indicted or summoned to answer for any criminal offense or Α. 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. Charge Location-City and State Deposition/Date Arresting Agency Date of Arrest Age Has a criminal indictment, information or complaint ever been returned against you, but for which you were not B. arrested or in which you were named as an unindicted co-party? Yes No It yes, furnish details on page 10. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission C. or committee? Yes □ No □ Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or D. commission? Yes □ No 図 Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? E. Yes □ No 🔯 Have you ever had a civil or criminal record expunged or sealed by a court order? Yes ☐ No ☑ F. If yes, when?\_\_\_\_\_city, county and state\_\_\_\_\_ Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☐ If yes when? city, county and state Has any member of your family or of your spouse's family ever been convicted of a felony? Yes \( \Bar{\text{N}} \) No \( \Bar{\text{X}} \) Η.

	Relationship	Charge	Location	Date
N/A				

Applicant's initial Ar

## 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 of	details below	List all cases without e	exception, including bankru	ıptcies:			
	Defendant or t/Respondent	Date Filed	Court and Case Number	City, County and State	Di	sposition/Date		
	N/A			ony, oddiny drig dialo		Specialory Date		
J.	associated v	vith it as an c	ship, business venture, sowner, officer, director of mplete the following:	sole proprietorship or close r partner) been a party to a	ly held corporation	on (while you were on or bankruptcy?		
	Name of Entity		Type of Entity		proximate Date(s) of wsuit/Arbitration/Bar			
	N/A							
•••					TO COMPANY OF THE PARTY OF THE			
				***************************************				
	ESIDENCES:	ou have had f	or the last 25 years:					
Month a								
(From	-10) 2001- present		Street and Number	City Hanover	State or Cou	nty		
	1994 - Oct 20			Scottsdale				
iviay	1994 - Oct 20	101	10267 N.136th Street	Scottsdale	AZ			
<del></del>								
· · · · · · · · · · · · · · · · · · ·								
·						· · · · · · · · · · · · · · · · · · ·		
	<del></del>					· · · · · · · · · · · · · · · · · · ·		
		, , , , , , , , , , , , , , , , ,						

Applicant's initial A

### 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	Sold company 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_	$A_r$	
		Page 6

### 9. CHARACTER REFERENCES:

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

Name of						
	Where Employed	Street	City State	Zip	Telephone Yes	ars Known
Name	Dayton Nordin	Home	Hingham, MA			12
Employe	Ernst&Young LLP	Business	200 Clarendon St. Boston, MA	02116		
Name	Roslyn Guy	Home	Lowell, MA			15
Employe	Ernst&Young LLP	Business	200 Clarendon St. Boston, M.	A 02116		
Name	Gary Silaci	Home	Lynn, MA			12
Employe	F Emst&Young LLP	Business	200 Clarendon St. Boston, MA	4		
Name	Debbie Tornabeni	Home	Las Vegas, NV	····		20
Employe	r n/a	Business	n/a			
Vame	David MacKinnon	Home	Newton, MA			15
Employe	Emst&Young LLP	Business	200 Clarendon St. Boston MA	A 02116		
10.	person's depos If yes, complet	itory? Yes □ te the followi	No 💢 ng:		ess to any depository or do y	ou use any other
3ox Num	ber or Type of Depo	sitory	Location	City and State	Authorized Users	
····· <u>u</u>	N/A		······································	<b></b>		
			~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~			**************************************
11.	the following: Liquor Doctor Accountant	held a privileg Lawyer Contractor Pilot	Race horse/r	ace dog owner oroker or salesman	ense in any state, including t Securities dealer Barber/Cosmetolog Trainer or manager	Insurance pist Gaming
11.	the following: Liquor Doctor	Lawyer Contractor Pilot	Race horse/r Real estate b Sports promo	ace dog owner oroker or salesman	Securities dealer Barber/Cosmetolog	Insurance pist Gaming
11.	the following: Liquor Doctor Accountant Yes 🗵 No 🗆 If yes, state type	Lawyer Contractor Pilot e, where and	Race horse/r Real estate b Sports promo	ace dog owner proker or salesman oter	Securities dealer Barber/Cosmetolog	Insurance gist Gaming
11.	the following: Liquor Doctor Accountant Yes 🗵 No 🗆 If yes, state type	Lawyer Contractor Pilot e, where and rtified Public	Race horse/r Real estate b Sports promo years held Accountant (CP	ace dog owner proker or salesman oter	Securities dealer Barber/Cosmetolog Trainer or manager	Insurance pist Gaming
11.	the following: Liquor Doctor Accountant Yes 🔞 No 🗆 If yes, state type  Ce  Cer  Have you ever a interest in a lice If yes, state type	Lawyer Contractor Pilot e, where and rtified Public rtified Public applied for a consed busines e, when and womes and add	Race horse/r Real estate be Sports promote years held  Accountant (CP) Accountant (CP) city, county of states or industry OU where and give no	ace dog owner broker or salesman oter  A), MA 16 years A), AZ 12 years te business, ventur TSIDE the State of ames and locations	Securities dealer Barber/Cosmetolog Trainer or manager	Insurance gist Gaming Educator  a financial  you were
12.	the following: Liquor Doctor Accountant Yes IN No If yes, state type  Ce  Cer  Have you ever a interest in a lice If yes, state type involved, the na venture or indus	Lawyer Contractor Pilot e, where and rtified Public applied for a consed busines e, when and womes and addistry.	Race horse/r Real estate to Sports promote years held  Accountant (CP Accountant (CP city, county of states or industry OU where and give notes of all partne	ace dog owner proker or salesman oter  A), MA 16 years A), AZ 12 years te business, ventur TSIDE the State of ames and locations rs and the agency r	Securities dealer Barber/Cosmetolog Trainer or manager  e or industry license or held Nevada? Yes 🔞 No 🗆 of the businesses in which	Insurance gist Gaming Educator  a financial you were d business,
12. Ernst &	the following: Liquor Doctor Accountant Yes IN No I If yes, state type Ce  Have you ever a interest in a lice involved, the na venture or indus  Young LLP US (as a	Lawyer Contractor Pilot e, where and rtified Public rtified Public applied for a consed busines e, when and wimes and addistry.	Race horse/r Real estate to Sports promote years held  Accountant (CPACCOUNTAINT)  Acc	ace dog owner proker or salesman oter  A), MA 16 years A), AZ 12 years te business, ventur TSIDE the State of ames and locations rs and the agency r	Securities dealer Barber/Cosmetolog Trainer or manager  e or industry license or held Nevada? Yes 🔞 No 🗆 of the businesses in which esponsible for licensing said	Insurance gist Gaming Educator  a financial you were d business,

Applicant's initial Page 7

13.	Have you ever appeared before any licensing agency any reason whatsoever? Yes □ No ☒	or similar authority in or outside the	State of Nevada for		
14.	Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes □ No ☑				
If yes t	o the above, state where, when and for what reason:				
15.	Have you ever been refused a business or industry lice participant in any group which has been denied a busi suitability?	ness or industry license or related t	or been a finding of Yes □ No ☑		
16.	Have you or any person with whom you have been a padministrative action or proceeding relating to the pha	participant in any group been the sumaceutical industry?	ubject of an Yes □ No ⊠		
17.	Have you or any person with whom you have been a puilty or entered a plea of nolo contendere to any offer controlled substances?	participant in any group ever been to nse, federal or state, related to pre-	found guilty, plead scription drugs and/or Yes □ No □		
18.	Have you or any person with whom you have been a permit or certificate of registration relating to the phare upon voluntary close of a manufacturer	participant in any group ever surrer naceutical industry voluntarily or ot	ndered a license, herwise (other than Yes □ No ☑		
19.	Do you have any relatives within the fourth degree of pharmaceutical or drug related industry?	consanguinity associated with or e	mployed in the Yes □ No ⊠		
**********					
			Į.		
•		F	Andrewin mayore		
*******					
********					
		Date of photograph 6/10/	2.16		
	-	Applicant's initial	Ard Page (		

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.
Original Signature of Applicant  fersonal information And personal  Subscribed and Sworn to before me this day of  Confidential basis And is only by share  Confidential basis And is only by share
Sune Jolly whatself by peasons with a weal to know the proposes of general a NEVADA  The grapuses of general a NEVADA  Ame to heave /An?

STEPHEN J. POOLE

Notary Public, Commonwealth of Massachusetts
My Commission Expires November 11, 2022

Notary Public

(seal)

Applicant's initial Page 9

# APPLICATION TO BE THE MDEG ADMINISTRATOR

## Person who runs the facility on a daily basis

Date June 10, 2016

150

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 equip	ment administrator.
· Ibbu and a second		lature of MDEG
	Medical Equipment Inc.	2780 S. Jone Blvd. Las Vegas NV 89146
Name	and Address of Busines	s for Which MDEG Administrator Is Requested
N/A -	Newly formed company in NV	
	If applicable, Name	e Under Which It Is Now Operated

## 1. PERSONAL INFORMATION:

Petrilli		Angelo			٧.
Last Name		First Name			Middle Name
n/a					
Alias(es, Nicknan	nes, Maiden Nai	me, Other Nai	ne Changes	s, Legal or Otl	nerwise)
go:				Hanover	MA +
Present Residence	ce Address-Stre	et or RFD		City	State/Zip
Ena	wa	Dates	Las Ve	egas	NV 89131
Present Business	Address		City		State/Zip
President / sole si	hareholder	Dates Since	formation on	June 8, 2016	
Present Position	with the MDEG		1111111	<u> </u>	
Phone:	~ m 1 V 1		Fax:		
Email address: _					
Date of Birth		Pittsburgh, A	Allegheny, PA (City, Cour		
			(Only)	ny, otato)	
		Social Securi	ty Number		M Sex
		Oociai Oecuii	ty Number		Sex
Brown	Brown		250		6'1"
Color of Eyes	Color of Hair		Weight		Height
Scars, tattoos or o	distinguishing ma	arks and/or ch	aracteristic	s	
Are you e citizen	of the United Cta	12 V D	N	· · · · · · · · · · · · · · · · · · ·	
Are you a citizen o					
f alien, registratio	n <b>N</b> o	,			
f naturalized, cert					
Place					cument must be verific
				aturanzeu, uu	Sament mast be AGIIII

### **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 diagnose or a physical condition that would impair my a license, including alcohol or substance abuse	ed or treated in the last five years for a mental illnes ability to perform any of the essential functions of my
1. I have □ I have not⊠ been charged	d, arrested or convicted of a felony or misdemeanor.
<ol> <li>I have □ I have not ☑ been the subjection</li> </ol>	ject of an administrative action whether completed o
<ol> <li>I have □ I have not □ had a license disciplined, including any action agains</li> </ol>	suspended, revoked, surrendered or otherwise at a professional license that was not made public.
If you checked "I have" to questions 1, 2 and/o provide a written explanation and/or documen	or 3, please include the following information <u>and</u> its.
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 aw	
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 M during its normal operating hours?	IDEG Yes ⊠ No ⊠
f you answer No to questions 4, 5 or 6 please	provide a written
see attached	A. A
***************************************	
	Date of photograph 6/11/2-1し

, being duly sworn, depose and say I have Angelo Petrilli 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

Personal information of applicant has been prograted on a confidential basis and prograted used should be the persons who

has a weed to know for proposer of genetical A Neurola Donate hieral A.

# 2-1

# APPLICATION TO BE THE MDEG ADMINISTRATOR Person who runs the facility on a daily basis

S Date June 10, 2016
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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 equip	ment administrator.
	1	lature of MDEG
Helix M	edical Equipment Inc.	2780 S. Jone Blvd. Las Vegas NV 89146
Name a	nd Address of Business	for Which MDEG Administrator Is Requested
N/A - Ne	ewly formed company in NV	,
	If applicable, Name	Under Which It Is Now Operated

## 1. PERSONAL INFORMATION:

Petrilli	Debo	orah	Lynn	
		irst Name	Middle Name	
n/a	Maidan Nama Otho	r Nama Changas I agal or C	Othenwise)	
Alias(es, Nicknam	es, Maiden Name, Other	r Name Changes, Legal or C	Julei Wise)	
		Hanover	MA	
Present Residence	e Address-Street or RFD	City	State/Zip	
5913 Lone Ranch Av	ve Dates	Las Vegas	NV 89131	
Present Business	Address	City	State/Zip	
Public Health Advis	or <u>Dates</u>	Since formation on June 8, 2016	)	
Present Position v				
Phone:		Fax:		
Email address: _				
		gh, Allegheny, PA		
Date of Birth	Place of	f Birth (City, County, State)		
54			<u>F</u>	
Age	Social S	Security Number	Sex	
Brown	Brown	145	5'5"	
Color of Eyes	Color of Hair	Weight	Height	
Scare tattone or o	distinguishing marks and	t/or characteristics		
Scars, lattous or t	Asinguishing marks and	aror orial actoricaco		
Are you a citizen	of the United States?	Yes ⊠No □		
If alien, registration	on No			
If naturalized, cer	tificate No	Date		
Place	V	(If naturalized,	document must be veri	
Place		(ii fiaturalizeu,	document mast be ven	

### **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.

	Partners Health Care / Massachusetts General Hosp	ital
2004 to 2016	Fruit Street, Boston MA	1500+
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Registered Nurse	Intensive care unit - patient care	n/a
Title	Description of Duties	Name of Supervisor
	Scottsdale Memorial Hospital	
1990 to 2001	Shea Blvd, Scottsdale AZ	1500+
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Registered Nurse	Oncology unit, Surgical unit, then Intensive care un	it - patient care n/a
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
Γitle	Description of Duties	Name of Supervisor

I have ☐ I have not ☒ been diagr or a physical condition that would impair n license, including alcohol or substance ab	ny ability to perform any of the esse	rs for a mental illness ential functions of my
1. I have □ I have not⊠ been char	ged, arrested or convicted of a felo	ony or misdemeanor.
<ol> <li>I have □ I have not ☑ been the sepending.</li> </ol>	subject of an administrative action v	whether completed or
<ol> <li>I have □ I have not □ had a lice disciplined, including any action against</li> </ol>	nse suspended, revoked, surrende ainst a professional license that wa	red or otherwise is not made public.
If you checked "I have" to questions 1, 2 a provide a written explanation and/or docur		ig information <u>and</u>
a) Board Administrative Action:		
b)	Date:	
	Case Number:	
c) Criminal Action:	State:	
	Date:	·
	Case Number:	
	County:	
	Court:	
4. Will you be actively involved in an operation of the MDEG?	nd aware of the daily	Yes ⊠ No □
5 .Will you be employed fulltime with	the MDEG?	Yes ☑ No 🗆
6 .Will you be present at the site of the during its normal operating hours?	ne MDEG	Vac 🗵 No 🗵
If you answer No to questions 4, 5 or 6 ple	ease provide a written letter c	
see attached	ATTACI	
	TAKE	
	30	
,	Date of photograph	1/10/2011

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.

Original Signature of Applicant

Personal internation of Applicant has bee

provided on a confidential basis and,

only to be shared on the or used by person

who have a need to know for proposes of

genetics a Need to Domete Ineme.

Page 5 – MDEG Administrator

## **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
☐ 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.
Please check box for type of ownership and complete confect part of the application.
GENERAL INFORMATION to be completed by all types of ownership
MDEG Name: EMMANUEL BIABENE OZOMOY MEDICALSUPPLE
Physical Address: HH81 W. RENO AUE, LAS VEGAS, NV 89118  (This must be a business address, we can not issue a license to a home address)
Mailing Address: <u>SAME AS ABOVE</u>
City: LAS VEGAS State: NV Zip Code: 89118
Telephone: 702629-6845 Fax: 702 6295054
E-mail:
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 9100to 5100 Tue: 9AM to 5PM Wed: 9AM to 5PM Thu: 918M to 5PM
Fri: 9AM to SPM 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)
<ul> <li>✓ Medical Gases**</li> <li>✓ Respiratory Equipment**</li> <li>✓ Parenteral and Enteral Equipment**</li> </ul>
☑ Respiratory Equipment**    ☐ Life-sustaining equipment**    ☐ Orthotics and Prosethics
☐ Diabetic Supplies Other:
**If providing these types of services you are required to have in place a mechanism to ensure
continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: EMMANUEL BIARENE Telephone: 7026296845

Page 1

012465

This page must be submitted for all types of ownership.

List a	ll Medicare and Medicaid provider numb	ers registered	d to the	business or it	s owner	:
646	6110001					
<u>175</u>	2030 <i>6</i> 889					
1)	Do any shareholders hold an interest o any type of business or facility which are or another political jurisdiction?				Yes 🛱	No □
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?				Yes □	No <sup>™</sup> X
3)	Are any of the owners health profession  ☐ Practitioner  ☑ Advanced Practitioner of Nursing ☐ Physician's Assistant ☐ Physical Therapist ☐ Occupational Therapist ☐ Registered Nurse ☐ Respiratory Therapist	Name: FEST Name: N	5TUS	check the box		

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

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 \
attach	answer to questions 1 through 5 is "yes", a signed statement of explanation ed. Copies of any documents that identify the circumstance or contain an over disposition may be required.	n must be order, agreement,
I unde	by certify that the answers given in this application and attached documentation a rstand that any infraction of the laws of the State of Nevada regulating the operat ized MDEG provider or wholesaler may be grounds for the revocation of this pern	ion of an
penalty hereby any inv reputa	read all questions, answers and statements and know the contents thereof. I here y of perjury, that the information furnished on this application are true, accurate a y authorize the Nevada State Board of Pharmacy, its agents, servants and employ vestigation(s) of the business, professional, social and moral background, qualific tion, as it may deem necessary, proper or desirable.	nd correct. I yees, to conduct
	nmanuel Cabene	
_	al Signature of Person Authorized to Submit Application, no copies or stam	nps
	MANUEL BIABENE 11/20/2015	, a
Print I	Name of Authorized Person Date	
Board	Use Only Received: 4 12 16 Amount: 500	•

## **OWNERSHIP IS A PARTNERSHIP**

List nar	nes of 4 largest partners and percentage of ownership:	
Name:	EMMANUEL BIABENE	%: <i>50</i>
Name:	FESTUS EBONKA	%: <u>50</u>
Name:	NIA	%: N/A
Name:	NIA	%: N/A
Partner	ship Name: <u>0'ZOMOR MEDICAL</u>	SUPPLIES
Mailing	Address: 4481 W. RENO AVE	
City: _	LAS VEGAS State: NV	Zip Code: 89118
	one Number: <u>7026296845</u> Fax Number:	
Contact	Person: EMMANUEL BIABENE	

## **PARTNERSHIP**

## Include with the application for a partnership

<u>Complete personal history record</u> 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

Spate 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 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.

Name and Address of Establishment for Which License is Requested  NOT APPLICABLE  If applicable, Name Under Which It is Now Operated  1. PERSONAL INFORMATION:  ast Name  BIABENE  BIABENE  MIddle Name, Other Name Changes, Legal or Otherwise)  BIABENE  BIABENE  BIABENE  MOMATE  EMMANUEL  City  State/Zip  WY 89118  Present Business Address  City  State/Zip  WY 89118  NOTATION  Dates  City  State/Zip  WY 89118  Decupation  Dates  City  State/Zip  WY 89118  Phone: Residence  Residence  Business  Action of Birth  Place of Birth (City, County, State)  Decupation  BAOWN  BUKK  Color of Hair  Complexion  Weight  Build  Height  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Place of the United States? Yes Mo I If alien, registration No.  NAA  Proceedings  Proceedings  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Residence  Sex  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  NAA  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  Procedure  Procedure  Procedure  Are you a citizen of the United States? Yes Mo I If alien, registration No.  Procedure  Pro	## First Name ####################################		If a	onlicable Name Unde	Which It Is Now Ope	rated		
BIABENE MOMATE EMMANUEL  resent Residence Address-Street or RFD	## MOMATE   MOMATE   MOMATE			opiicable, Name Onde	William to Non Ope	. atou		
BIABENE   MOMATE   EMMANUEL	NE MOMATE EMMANUEL  IDEA Address-Street or RFD  Dates  LAS VEGAS  State/Zip  State/Zip  State/Zip  State/Zip  State/Zip  State/Zip  State/Zip  Phone: Residence  Residence  Residence  Place of Birth (City, County, State)  MALE  Social Security Number  Sex  BUCK  Color of Hair  Complexion  Weight  Build  Height  Sor distinguishing marks and/or characteristics  PRESCRIBED  GLASSES  Item of the United States? Yes No If alien, registration No  N/A  I, certificate N  Date O!/25/2013  DISTRICT COURT, LAS VEGAL, N.V. (If naturalized, document must be verified.)	BIADENE		EMMAN	UEL	Middle Name MOMA	7E	
THE STATE OF PERATION  Dates  City  State/Zip  Phone: Residence  Residence  Business  Are you a citizen of the United States? Yes No □ If alien, registration No N/A  State/Zip  State/Zip  State/Zip  State/Zip  Phone: Residence  Residence  Residence  State/Zip  Phone: Residence  Residence  Residence  State of Birth  Place of Birth (City, County, State)  MALt  Sex  Sex  Sex  Sex  Sex  Sex  Sex  Se	REND SAddress City State/Zip  TOL 6296845  Phone: Residence Residence  Business  Place of Birth (City, County, State)  MALE  Social Security Number Sex  Color of Hair Complexion  Social Security Number Sex  Color of Hair Complexion  Weight  Build  Height  Social States? Yes No If alien, registration No  N/A  I, certificate N  Date  O1/25/2013  D16TRICT COURT, LAS VEGAL, N.V. (If naturalized, document must be verified.)	lias(es, Nicknames, Maid						
Dates    Coupation   Dates   Phone: Residence   Phone: Pho	Social Security Number  Social Security Number  Color of Hair  Sor distinguishing marks and/or characteristics  Place of the United States? Yes No□ If alien, registration No  Date 01/25/2013  District Court, LAS VEGAS, N.V. (If naturalized, document must be verified.)							
Coma, Congo - Kinshasa  Business  Place of Birth (City, County, State)  MALt  ge Social Security Number Sex  BROWN BLACK 180 5'7"  Color of Eyes Color of Hair Complexion Weight Build Height  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	Social Security Number  Social Security Number  Color of Hair  Sor distinguishing marks and/or characteristics  NALE  Social Security Number  Sex  BLACK  180  5'7'  Color of Hair  Complexion  Weight  Build  Height  Social Security Number  Sex  ALSE  Sex  Color of Hair  Complexion  Weight  Build  Height  Social Security Number  Sex  ALSE  Social Security Number  Sex  Color of Hair  Complexion  Weight  Build  Height  Social Security Number  Sex  ALSE  Social Security Number  Sex  DLASSES  Izen of the United States? Yes No □ If alien, registration No N/A  I, certificate N  Date 01/25/2013  DISTRICT COURT, LAS VEGAS, N.V. (If naturalized, document must be verified.)			Ci	ty			
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ge Social Security Number Sex  BROWN BLACK 180 5'7" olor of Eyes Color of Hair Complexion Weight Build Height  Scars, tattoos or distinguishing marks and/or characteristics PRESCRIBES GLASSES  Are you a citizen of the United States? Yes No □ If alien, registration No N/A	Social Security Number  BLACK  Color of Hair  Complexion  Weight  Build  Height  Sex  180  5'7'  Color of Hair  Complexion  Weight  Build  Height  Sex  Height  Social Security Number  180  5'7'  Color of Hair  Complexion  Weight  Build  Height  Sex  Height  Sex  Sex  Data Self  Data Se	oto of Pirth	Goma	CONGO - K	INSHASA	Business		
BROWN BLACK 180 577 olor of Eyes Color of Hair Complexion Weight Build Height Cars, 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	BLACK Color of Hair Complexion  Neight  Build  Height  s or distinguishing marks and/or characteristics  RESCRIBED  GLASSES  izen of the United States? Yes No I If alien, registration No  Date 01/25/2013  DISTRICT COURT, LAS VEGAS, NV (If naturalized, document must be verified.)		,	race of Birth Colly, Oc	only, Olato)	M	ALt	
Scars, tattoos or distinguishing marks and/or characteristics PRESCRIBES GLASSES  Are you a citizen of the United States? Yes ✓ No □ If alien, registration No N/A	Sor distinguishing marks and/or characteristics PRESCRISES GLASSES  izen of the United States? Yes No□ If alien, registration No N/A  I, certificate N  Date OI/25/2013  DISTRICT COURT, LAS VEGAS, NV (If naturalized, document must be verified.)		Social Sec	urity Number	120		Sex	
are you a citizen of the United States? Yes $rac{V}{}$ No $\square$ If alien, registration No $N/A$	izen of the United States? Yes No □ If alien, registration No N/A  I, certificate N Date 01/25/2013  D16TRICT COURT, LAS VEGAS, NV (If naturalized, document must be verified.)	<del></del>	Color of Hair	Complexion		Build	Height	
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	Date 01/25/2013  District Court, Las VEGAS, NV (If naturalized, document must be verified.)							
Continue the side of a subtiliar at a Ni	DISTRICT COURT, LAS VEGAS, NV (If naturalized, document must be verified.)							
	·	naturalized, certifica						
lace US DISTRICT COURL, LAS VEGAS, NV (If naturalized, document must be verified	L INFORMATION:	lace	ICI COURI,	LAS VEGAS, N	V (If naturali	zed, document n	nust be verified.)	
2. MARITAL INFORMATION:		2. MARITAL INFO	RMATION:					
Single $\square$ Married X Separated $\square$ Divorced $\square$ Widowed $\square$ Engaged $\square$ Applicant's initial $ olimits \mathcal{E} \mathcal{B}$		Single 🗆 Married	Separated	☐ Divorced	□ Widowed		_	

MARI		ATION-Continued				
A.	Current Ma	rriage	PRISCILLA BUNYE	egors, Cla	rk count	1. Nevador
	Spouse's fu	ll name (Maiden)	PRISCILLA BUNYE	RE BIABENE	City, County area	State
	Date of Birth	12/24/1	984 Pla	ce of Birth C	ONGO - H	KINSHASA
			MLGREGOR			
	Telephone:	Residence	•••	Business	-	
	Spouse's en	nployer £xc	ALIBUR	Occupation	GUEST	ROOM
			S LAS VEGAS			
		Street		City	State 2	Zip
B. P	revious Marri	ages: If ever lega	ally separated, divorced	l, or annulled, indi	cate below:	
Name	of Spouse	Date of Order or Decree	Date of Plac of Marriage			y and State
	NIA	NI A	+ NIA		IA NI	
	1/	114	NIA	NIA	1/11	
	<i>\V</i>	1/14	MIA	- 1/1	1	TrA
	1	70/7(			7 10	
	List of name Name		s and telephone numbe City	rs of previous spo State	ouses: Zip	Telephone
	NIA	NI	$A$ $N_{I}$	4 NI	A NIA	NIA
	NIF	7				
3. FA	MILY INFOR	MATION:				
Α.	Children an	d Dependents:	stop shildren and adam	المراجع والمراجع المراجع	aire the Collection	
	Lisi ali (	amaren, including	step-children and ador	ted children and	give the following sidence Addres	
В.		ort Information: se mark the appro	opriate response:			
	¥۱	am not subject to	a court order for the su	pport of child.		
	pl	lan approved by th	ourt order for the suppo ne district attorney or ot d pursuant to the order;	her public agency	children and am in enforcing the ord	n compliance with a der for the repayment
	th	e order or a plan	ourt order for the suppor approved by the district se amount owed pursua	attorney or other	children and NOT public agency en	forcing the order for £ B
						Page 2

FAMIL	Y INFORMATIO District attorney			nforcing the child support order:	
	Name/				
	Address				
	Contact person				
C.	Parents:				
parents	•	sidence addr	esses, dates of birth and	d most recent occupations of parent	s, step-parents,
		guardian. If		last address and occupation.	Occupation
	Name (Maigen)		Birth Date Ad	uress	Occupation
Father	64 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CCA	interestorial z	CALLED KINGS ACA	. 1612 616. 131
Mother	MA KWA	ISSA	UNKBOWN C	LON 60-KINSHASA	UNKNOWN
ROS	BALIE KA	BUO K	RAPITULA UNKNI	OWN CONGO-KINSHASA	UNKNOWN
Father-in					
	ocis				
Mother-ir		KARU	M/A		
C	ECILE	KAKU	NGU		
D.	Brothers and				
	List names, res their respective		esses, dates of birth and	d most recent occupations of brothe	rs and sisters and of
	Name (Maiden)		Birth Date Ad	dress	Occupation
	EE MON	1 <i>A</i>	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Spouse	NKNOWN		UNKNOWN	UNKIYOWN	UNKNOWN
В	AGUMA B	IABENE	UNKOWN	I CONKERKINSHALL	UNKBOWN
Spouse	NKNOWA		UNKNOWN	CONGO-KINSHASA	UNKNOWN
	EBECCA B	MARFNE	UNKNOWN	CONGO-KINSHASA	UNKNOWN
Snouse	INKNOWN	717 (37) (37)	INKNOWN	CONGO-KINSHASA	•
		SIABENE		CONGO-KINSHASA	UNKNOWN
Spouse	VIANO I	) in of ive	UNKNOWN	CDNOO-ILINSHADA	
	UNKNOWM		UNKNOWN	CONGO-KINSHASA	UNKNOWM
4. ED	UCATION:				
	Name of		Location	Dates Attended	Graduate
Grammai School	ECOLE PR			KINUHASA 7/88-9190	Yes M No 🗆
High School	college	MWAN	GA CONGO	KINSHASA 7/99-10/99 MG CONGO 5/20-7/2004	Yes M No 🗆
College Universit	,				Yes 🗆 No 💆
Other	UNIVERS	TY OF	PHOENIX	4/10 - 10/12	Yes V No 🗆
Type of	f degree obtaine	d, if anyA	SSOCIATE DE	GREÈ	
College	e or university w	here obtaine	d UNIVERSITY	OF PHOENIX	

Applicant's initial Eb Page 3

## 5 MILITARY INFORMATION: Yes □ No 🗹 A. Have you ever served in any armed forces? Date of entry-active service N/A Date of separation N/A Type of discharge N/A Rating at separation W/A Serial number W/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.) Yes □ No 1X B. Have you registered for the draft? State N/T Date registered N/A County 6. ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (Include those arrests in which you were not convicted.) 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 X If yes, give details in space provided below. List all cases without exception. Date of Arrest 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 X If yes, furnish details on page 10. Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission C. or committee? Yes 🗆 No 💢 Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or D. commission? Yes □ No 🖄 E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes □ No 🛛 Have you ever had a civil or criminal record expunged or sealed by a court order? Yes □ No 匆 F. G. H. If you answer to any of the above questions (B through H) is yes, furnish details on page 10. Name Relationship Charge

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## ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

	as either a pl (Other than d ils below. Lis	livorces) st all cases without exc	eption, including bankruptci	es:
Plaintiff/Defendant or Claimant/Respondent	Date Filed	Court and Case Number	City, County and State	Disposition/Date
NIA		NA		NIA
/	VIA	•	NIK	
NIA				NIA
J. Has any general associated with Yes □ No □ I	it as an owne	er, officer, director or pa	e proprietorship or closely hartner) been a party to a law	eld corporation (while you we suit, arbitration or bankruptcy
Name of Entity		Type of Entity		timate Date(s) of t/Arbitration/Bankruptcy
Name of Entity		V/A	Lawsui	VCA
NIA		NIA		VER
NIA		NIA		IIX
NIA		NIA	Λ	IA
7. RESIDENCES:		NIA	Λ	liA
	ave had for th		Λ	li A
7. RESIDENCES: List all residences you have the control of the con			∠ City	State or County
List all residences you h	Street	he last 25 years:		State or County  NU 84032
List all residences you had the control of the cont	Street	he last 25 years:		_
List all residences you have the control of the con	Street	he last 25 years: t and Number ICGREGOR WAY	N.LAS VEGAS	NU 89032
List all residences you have (From-To)  1/2014 70 DATE  1/2010 to 10/2014  0/2008-10/2010	Street 3831 M 26/2 11 810	he last 25 years: t and Number  N.G.REGOR WAY  NIVOVATION CT  M. STREET	N.LAS VEGAS N.LAS VEGAS LAS VEGAS	NU 89032 NV 89031
List all residences you have (From-To)  1/2014 70 DATE  1/2010 to 10/2014  0/2008-10/2010	Street 3831 M 26/2 1/ 810 2635 1	he last 25 years:  t and Number  N.G.REGOR WAY  N.YOVATION CT  M STREET  YNN WOOD ST.H3	N.LAS VEGAS N.LAS VEGAS LAS VEGAS O LAS VEGAS	NU 89032 NV 89031 NV 89106
List all residences you had the (From-To)  1/2014 70 DATE  1/2010 to 10/2014  0/2008-10/2010  1/2008-09/2008	\$\frac{3831 M}{26/2 \line{1}}\$\frac{810}{2635 \line{1}}\$	he last 25 years:  t and Number  NOGREGOR WAY  NIVOVATION CT  M STREET  YNNWOOD ST:#3  AST SAHARA AU	N.LAS VEGAS  N.LAS VEGAS  LAS VEGAS  IO LAS VEGAS  VE LAS VEGAS	NU 89032 NV 89031 NV 89106 NV 89104
List all residences you have (From-To)  1/2014 70 DATE  1/2010 to 10/2014  0/2008-10/2010  1/2008-09/2008  1/2007-01/2008	Street 3831 M 26/2 1/ 810 2635 1 710 £	he last 25 years:  t and Number  N.G.REGOR WAY  N.YOVATION CT  M STREET  YNN WOOD ST.H3	N.LAS VEGAS  N.LAS VEGAS  LAS VEGAS  IO LAS VEGAS  VE LAS VEGAS	NU 89032 NV 89031 NU 89106 NU 89104 NV 89104
List all residences you have (From-To)  1/2014 70 DATE  1/2010 to 10/2014  0/2008-10/2010  1/2008-09/2008  1/2007-01/2008  2/1976 - 07/20	Street 3831 M 26/2 1/ 810 2635 1 710 £	he last 25 years:  t and Number  NOGREGOR WAY  NIVOVATION CT  M STREET  YNNWOOD ST:#3  AST SAHARA AU  GOMA	N.LAS VEGAS  N.LAS VEGAS  LAS VEGAS  IO LAS VEGAS  VE LAS VEGAS  KAKUMA	NU 89032 NV 89031 NV 89106 NV 89104 NV 89104 KENYA
List all residences you had the common to the common of th	Street 3831 M 26/2 1/ 810 2635 1 710 £	he last 25 years:  t and Number  NICGREGOR WAY  NIVOVATION CT  M STREET  YNNWOOD ST.#3  AST SAHARA AU  AKUMA CAMP	N.LAS VEGAS  N.LAS VEGAS  LAS VEGAS  LAS VEGAS  LAS VEGAS  KAKUMA  GOMA	NU 89032 NV 89031 NV 89106 NV 89104 NV 89104 KENYA CONGO-KINSHAS
List all residences you have (From-To)  1/2014 70 DATE  1/2010 to 10/2014  0/2008-10/2010  2/2008-09/2008  18/2007-01/2008  2/1976 - 07/20	Street 3831 M 26/2 1/ 810 2635 1 710 £	he last 25 years:  t and Number  NOGREGOR WAY  NIVOVATION CT  M STREET  YNNWOOD ST. HI  AST SAHARA AU  AKUMA CAMP  GOMA  NIK	N.LAS VEGAS  N.LAS VEGAS  LAS VEGAS  IN LAS VEGAS  KAKUMA  GOMA  NIA	NU 89032 NV 89031 NV 89106 NV 89104 NV 89104 KENYA CONGO-KINSHAS, N/A

#### 8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
01/2015	OZOMOR MEDICAL SUPPLIES 4481 W. RENO	STILL
Title	Description of Duties	Name of Supervisor
DIRECTOR OF OPERA	Tign Administration & Supervision	
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
05/2013	LACANADA PEDIATRICI 3006 S. MARYLANDPR	wy fower struckle
Title	Description of Duties	Name of Supervisor
OFFICE MANAGER	SUPERVISIONA ADMINISTRATION	DR ABBAS KINGÚ
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
10/2010	TERRIBLE HERBST 3440 W. RUSSEL RD	JOB ENRICHMENT
Title	Description of Duties	Name of Supervisor
CAFHIER	CASH HANDLING & CUSTOMER CARE	BROOKE
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/2009	USCENSUS BUREAU LAS VEGAS NV	END OF 2010 GENSU
Title	Description of Duties	Name of Supervisor
CREW LEADER	SUPERVISION and DATA ENTRY	DIANE IRELAND
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
9/2008	CATHOLIC CHARITIES 1501 NLASVEGAS	•
Title	Description of Duties	Name of Supervisor
Jub develofer	refugees Job flacement	LISA LEONE
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
09/2007	STRATOSPHERE CASINO LAS VEGAS NV	JOB ENRICHMENT
Title	Description of Duties	Name of Supervisor
BAR PORTER	ASSIST BARTENDER IN ALL THEIR NEED	LORI WIREACKY
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1918005	IRCKAKUMAHOSPITAL KAKUMA/KEN	· ·
09/2005 Title	Description of Duties	Name of Supervisor
HOSFITAL ADMI	INISTRATOR ADMINISTRATION & SUPERVINO	·
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
<u>0</u> 2/2002 Title		WAR
Title /	ORFAP CONGO-KINSHASA  Description of Duties	Name of Supervisor
ASSISTANT GENER	VAL MANAGER ADMINISTRATION & SUPERVISION	
	The state of the s	

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

Applicant's initial_	EB.	
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### 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 Empl	pyed Street	City State	Zip Te	lephone Ye	ears Known
Name CRAIG @	ARAWAY Home 14	107 BAREBACK C	T, HENDERSON		6 YEARS
	HENDERIN Business				
Name DAN VIR	KLER Home 7	137 PARAKEET A	UE LAS VEGAS	<u>-</u> -	8 YEARS
Employer	Business				
Name JEAN MARIE	BOLA Home 10	1506 GLOWING CC	IVE LAS VEGAS		& YEARS
Employer 5 un Co	<u>ast CostingBusiness</u>				0.16
Name BROOKE	Home				2 YEARS
	E HERBST Business				
Name Jeffrey	Hanks Home				<u> 7 YEARS</u>
Employer CLARK	COUNTY Business	COURT INTE	RPRETORIS O	FFICE	
person's of the person's of the person's of the person of the person of the person of the person's of the person of the	depository? Yes Demplete the follow	I No □ ring:		to any depository or do  Authorized Users	you use any othe
Box Number or Type		Location	City and State		
VALUABLE DOC	UMENTS	WELLS FARGO	LAS VEGAS NI		L BIABENE
NIA		NIA	NA	NIA	NIA
NIA		NIA	NIA	NIA	NIA
the follow Liquor Doctor Accounta Yes 🗆 N	ing: Lawyer Contractor nt Pilot	Race horse/rac Real estate bro Sports promote	ce dog owner oker or salesman er	se in any state, including Securities dealer Barber/Cosmetolo Trainer or manage	Insurance gist Gaming er Educator
MA	NA	l years held V ( A	NIA	NIA	NIA
NIA	NIA	NIA	NIT	NIA	
	si A	NIA	NIA	NIA	WIA
interest in If yes, sta involved,	n a licensed busine te type, when and the names and ad	ess or industry OUT: where and give nar dress of all partners	e business, venture of SIDE the State of Ne mes and locations of	or industry license or helevada? Yes ☐ No 🕱 the businesses in which sponsible for licensing sa	d a financial
				NIA	NIT
NI				NIK	
					EB.

13.	Have you ever appeared before any licensing agence any reason whatsoever? Yes D No D	y or similar authority in or outside the State of Nevada for A
14.	*	nit, certificate or registration for a privileged, occupational
If yes I	to the above, state where, when and for what reason:	
15.		cense or related finding of suitability or been a siness or industry license or related finding of
16.	Have you or any person with whom you have been a	
17.	Have you or any person with whom you have been a	participant in any group ever been found guilty, plead ense, federal or state, related to prescription drugs and/or Yes  No
18.	Have you or any person with whom you have been a permit or certificate of registration relating to the phar upon voluntary close of a manufacturer	participant in any group ever surrendered a license, maceutical industry voluntarily or otherwise (other than
19.	Do you have any relatives within the fourth degree of pharmaceutical or drug related industry?	consanguinity associated with or employed in the Yes □ No □
	N/A N/A	N/ A
	NIA	
	N/A N/A	
	NIA	
	N/A	
********	NA	Date of photograph <u>03/31/2016</u>
		Applicant's initial <i>EB</i> Page 8

STATE OF Worlds COUNTY OF Clark						
COUNTY OF OCarly	SS.					
COUNTY OF CO.	<u>~</u>					
	, being duly sworn, depose and say I have read the					
foregoing application and know the contents thereof; that						
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	f Nevada Statutes on Pharmacists and Manufacturer and the					
Controlled Substances Act, as amended, and the Regular	tions 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						
	censing agency and their agents, as a result of my applying					
for a manufacturer license in the State of Nevada.						
	Emmanul Giorber					
	Original Signature of Applicant					
-d'la						
Subscribed and Sworn to before me this	day of YANET ACEVEDO					
Aprol, 2016	NOTARY PUBLIC					
Along Blat)	STATE OF NEVADA  My Commission Expires: 11-01-2018					
Notary Public	Certificate No: 14-15562-1					
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(seal)					
	(Scal)					
	. <sup>8</sup>					
	•					