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 MP01317)

☐ 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: Bluebird MEDICAL Supply, INC.

Physical Address: 1400 S Decatur Blvd

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1400 S Decatur Blvd

City: Las VEGAS State: NV Zip Code: 89102

Telephone: 702.998-1437 Fax: 702.-998-0249

E-mail: bluebirdmedical7@gmail.com Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9am to 5pm Sat: close to Sun: close to Holidays: close to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: MARY MONICA Khamtrashyan

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

☐ Medical Gases**
☐ Respiratory Equipment**
☐ Life-sustaining equipment**
☒ Diabetic ~~Supplies~~ Shoes
☐ Assistive Equipment
☐ Parenteral and Enteral Equipment**
☒ Orthotics and Prosethics
Other: INCONTINENCE .

**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: MONICA Khamtrashyan Telephone: 702-466 5060

91280

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

pending	Medicare	
pending	Medicaid	

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

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

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

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

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

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

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

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

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

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

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

Simin Motallebi
Print Name of Authorized Person

12-07-15
Date

Board Use Only	Received:	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: NV

Parent Company if any: _____

Corporation Name: Bluebird MEDICAL supply, INC

Mailing Address: 1400 S DECATUR Blvd

City: LAS VEGAS State: NV Zip: 89102

Telephone: 702-998-1437 Fax: 702.998-0249

Contact Person: Simin Motallebi

For any corporation non publicly traded, disclose the following:

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

a) Simin Motallebi 1400 S DECATUR Blvd LV, NV 89102
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

2) Provide the number of shares issued by the corporation. 75000

3) What was the price paid per share? 0.10 #

4) What date did the corporation actually receive the cash assets? 10-22-15

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

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12-07-15

GENERAL INSTRUCTIONS

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

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

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

Application for DME
Nature of License

Bluebird MEDICAL Supply, INC
Name and Address of Establishment for Which License Is Requested

Bluebird MEDICAL Supply, INC
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
motallebi	Simin	

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

Present Residence Address-Street or RFD	City	State/Zip
9624 Tuscola ct	Las VEGAS	NV 89148

Present Business Address	Dates	City	State/Zip

Occupation — Dates

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

Color of Eyes	Color of Hair	Complexion	Weight	Build	Sex	Height
BROWN	BROWN		137		F	5'00"

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

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

If naturalize ..... Date June 13, 1997

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

2. MARITAL INFORMATION:

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

Applicant's initial S|M

MARITAL INFORMATION-Continued

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

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

Date of Birth ..... Place of Birth .....

Resident address ..... Street ..... City ..... State ..... Zip

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

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

Address of employer ..... Street ..... City ..... State ..... Zip

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

Name of Spouse	Date of Order or Decree	Date of Place of Marriage	Nature of Action	City County and State
Hector-Const629		LAS-VEGAS	Divorce	USA

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

Name	Street	City	State	Zip	Telephone
Hector-Const629	N/A	UNKNOWN			

3. FAMILY INFORMATION:

A. **Children and Dependents:**

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

Name	Birth Date	Birth Place	Residence Address
N/A			

B. **Child Support Information:**

Please mark the appropriate response:

☒ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial S/M

FAMILY INFORMATION-Continued

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

Name .....

Address .....

Contact person .....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Esfandiar Motalebi seysan		4751 Clover Ridge St Las VEGAS NV 89147	
Mother	Norges Zaheeli seysan		6588 Chimes Tower AV Las VEGAS NV 89139	
Father-in-Law				
Mother-in-Law				

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

	Name (Maiden)	Birth Date	Address	Occupation
Spouse	Shawn Motallebi		6588 Chimes Tower Ave Las VEGAS, NV 89139	
Spouse	Mahn Motallebi		4751 Clover Ridge st Las VEGAS NV 89147.	
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School				Yes ☐ No ☐
High School	Mahesti	Iran, Theran	09-01-1967	Yes ☒ No ☐
College University				Yes ☐ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any .....

College or university where obtained .....

Applicant's initial S | m

5 MILITARY INFORMATION:

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

Branch ..... Date of entry-active service .....

Date of separation ..... Type of discharge .....

Rating at separation ..... Serial number .....

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

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

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

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date

Applicant's initial S/M

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

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

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

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

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
09-2002 to 09-2004	4119 El Camino Ave	Las VEGAS	NV 89102
10-2004 to 10-2008	7182 Acorn Ct	Las VEGAS	NV 89117
11-2008 to 11-2009	7774 Little Ave	Las VEGAS	NV 89117
12-2009 to 12-2010	7182 Acorn Ct	Las VEGAS	NV 89117
01-2011 to 11-2014	4751 Clover Ridge St	Las VEGAS	NV 89148
12-2014 — NOW	9624 Tuscola Ct	Las VEGAS	NV 89148

Applicant's initial S/M

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
8-2000 to 01-2014	SunCost Hotel Casino 99 Alta DR LV, NV	after my surgery I can't work.
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Title	**Description of Duties**	**Name of Supervisor**

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 S/m

9. **CHARACTER REFERENCES:**

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

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Mahyar Honari	Home 9723 High Alpin st	Las VEGAS	NV	89178		20y.
Employer	Business					
Name Mohamand Honari	Home 9723 High Alpin st	Las VEGAS	NV	89178		3 10y
Employer	Business					12y.
Name Parvaneh najjary	Home 8350 W Desertinn APT#2029	Las VEGAS	NV	89117.		
Employer	Business					15y
Name Payam Zahedi	Home 8350 W Desertinn APT#209	Las VEGAS	NV	89117		
Employer	Business					
Name	Home					
Employer	Business					

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

Box Number or Type of Depository	Location	City and State	Authorized Users

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

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

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

.....

.....

.....

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

.....

.....

.....

Applicant's initial S/M

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

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

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

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

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

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

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

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

Date of photograph 12.04-15

Applicant's initial S|M

STATE OF NV

ss.

COUNTY OF USA Clerk County

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

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

Original Signature of Applicant

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

Notary Public

N. GONZALEZ
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 02-08-16
Certificate No: 12-7001-1

(seal)

Applicant's initial S M

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: Cintas Corporation No. 2

Physical Address: 250 Vista Blvd #107, Sparks, NV 89434
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 250 Vista Blvd #107,

City: Sparks State: NV Zip Code: 89434

Telephone: 775-352-1755 Fax: 775-352-1767

E-mail: HarrisonE@cintas.com Website: www.cintas.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 7:00 to 3:30 Tue: 7:00 to 3:30 Wed: 7:00 to 3:30 Thu: 7:00 to 3:30

Fri: 7:00 to 3:30 Sat: ___ to ___ Sun: ___ to ___ Holidays: ___ to ___

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Elisha Harrison

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

Medical Gases**
Respiratory Equipment**
Life-sustaining equipment**
Diabetic Supplies
Assistive Equipment
Parenteral and Enteral Equipment**
Orthotics and Prosethics
Other: First Aid Kits / OTC medication

**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: _____

90820

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

N/A

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

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

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

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

N/A

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

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

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

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

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

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

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

Jay Bruscato

Print Name of Authorized Person

10/23/15

Date

Board Use Only	Received: 11-10 15	Amount: 500-

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: Cintas Corporation

Corporation Name: Cintas Corporation No. 2

Mailing Address: 6800 Cintas Blvd.

City: Mason State: OH Zip: 45040

Telephone: 513-459-1200 Fax: _____

Contact Person: Bill Bradbury

For any corporation non publicly traded, disclose the following:

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

a) _____
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

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

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

3) What was the price paid per share? _____

4) What date did the corporation actually receive the cash assets? _____

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 10/21/15

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

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

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

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

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

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

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

Application for Manager of Distribution Center

Nature of MDEG

Cintas FAS DC 250 Vista Boulevard #105 Sparks NV 89434

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. **PERSONAL INFORMATION:**

Harrison (Last Name) | Elisha (First Name) | Keahalani (Middle Name)

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

9755 Silver Sky Parkway #2001 (Present Residence Address-Street or RPD) | Reno (City) | 89506 (State/Zip)

250 Vista Boulevard #107 (Present Business Address) | Dates 1994-Present | Sparks (City) | NV 894134 (State/Zip)

Distribution Center Manager (Present Position with the MDEG) | Dates Feb 2015-Present

Phone: 775-352-1755 | Fax: 775-352-1767

Email address: HarrisonE@cintas.com

Emmett, Gem, ID (Place of Birth (City, County, State)) | Date of Birth

35 (Age) | Social Security Number | Male (Sex)

Brown (Color of Eyes) | Black (Color of Hair) | 220 (Weight) | 5.11 (Height)

Scars, tattoos or distinguishing marks and/or characteristics Tattoo on arm & shoulder

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

If alien, registration No _____

If naturalized, certificate No _____ Date _____

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

EMPLOYMENT:

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

9/1/06 - 12/28/07 University of Idaho 709 S. Deakin St Moscow ID 83844

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

Emergency Response Instructor. Instructor for Under graduate students

Title | Description of Duties | Name of Supervisor

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

Title | Description of Duties | Name of Supervisor

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

Title | Description of Duties | Name of Supervisor

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

Title | Description of Duties | Name of Supervisor

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

Title | Description of Duties | Name of Supervisor

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

Title | Description of Duties | Name of Supervisor

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

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

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

a) Board Administrative Action: State: _____

b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

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

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

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

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

ATTACH PHOTOGRAPH

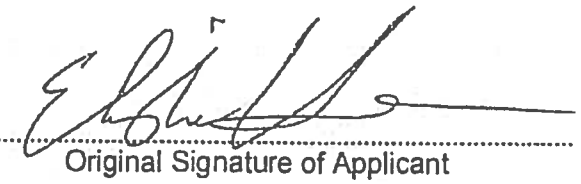
TAKEN WITHIN LAST

30 DAYS HERE

Date of photograph 9/30/15

I, Elisha Keahalani Harrison, 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

STATE OF NEVADA

BARBARA K. CEGAVSKE
Secretary of State

JEFFERY LANDERFELT
Deputy Secretary
for Commercial Recordings

Commercial Recordings Division
202 N. Carson Street
Carson City, NV 89701-4201
Telephone (775) 684-5708
Fax (775) 684-7138

OFFICE OF THE
SECRETARY OF STATE

Jason Stitt
Keating Muething & Klekamp PLL
1 East Fourth St., Ste. 1400
Cincinnati, OH 45202

Job:C20151007-1168
October 7, 2015

Special Handling Instructions:

Charges

Description	Document Number	Filing Date/Time	Qty	Price	Amount
Cert of Existence (good standing - short form)	11510-2000	4/26/2000	1	$50.00	$50.00
Total					$50.00

Payments

Type	Description	Amount
Credit	229769|15100795596742	$50.00
Total		$50.00

Credit Balance: $0.00

Job Contents:
Web Certificate of Good Standing 1
Short(s):

Jason Stitt
Keating Muething & Klekamp PLL
1 East Fourth St., Ste. 1400
Cincinnati, OH 45202

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

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

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **CINTAS CORPORATION NO. 2**, as a corporation duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since April 26, 2000, and is in good standing in this state.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on October 7, 2015.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Electronic Certificate
Certificate Number: C20151007-1168
You may verify this electronic certificate online at http://www.nvsos.gov/

Blank

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: HST, LLC

Physical Address: 9017 S. Pecos Rd. #4500, Henderson, NV 89074

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1000 N. Green Valley Pkwy, # 440-644

City: Henderson State: NV Zip Code: 89074

Telephone: 702-210-8466 Fax: 702-897-0574

E-mail: HSTNV@cox.net Website: N/A

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9 to 6 Sat: 10 to 2 Sun: — to — Holidays: — to —

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Christina Maltetta

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

☐ Medical Gases**

☒ Respiratory Equipment** APAP machines

☐ Life-sustaining equipment**

☐ Diabetic Supplies

☐ Assistive Equipment

☐ Parenteral and Enteral Equipment**

☐ Orthotics and Prosethics

Other: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Christina Maltetta Telephone: 702 210-8466

89804

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

143712 3411		
1184803801		

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

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

3) Are any of the owners health professionals? If yes, please check the box and list name. NO

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

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☒

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

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

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

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

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

Christina Maletta

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

Christina Maletta

Print Name of Authorized Person

8-17-15

Date

Board Use Only	Received: _____	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Christina Maltetta

Business Name: HST, LLC

Current Business Address: 9017 S. Pecos Rd, #4500

City: Henderson State: NV Zip: 89074

Telephone: 702 210-8466 Fax: 702-897-0574

SOLE OWNER

Include with the application for a sole owner

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

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 8-17-15

GENERAL INSTRUCTIONS

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

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

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

Application for dispensing of home sleep test and sale of cpap machine.
Nature of License

HST, LLC 9017 S. Pecos Rd. #4500, Henderson, NV 89074
Name and Address of Establishment for Which License Is Requested

HST, LLC
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Molfetta | Christina | —
Last Name | First Name | Middle Name

maiden name - Olivera
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

2246 Driftwood Tide Ave, Henderson, NV 89052
Present Residence Address-Street or RFD | City | State/Zip

9017 S. Pecos Rd. #3700 Dates | Henderson, NV | 89074
Present Business Address | City | State/Zip

Owner | Dates 9/01 - 6/08 & 9/13 - Present | Phone: Residence
Occupation

Business 702-896-7378

Detroit, MI
Date of Birth | Place of Birth (City, County, State)

45 | F
Age | Sex

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Brown	Brown	Olive	164	n/a	5'5"

Scars, tattoos or distinguishing marks and/or characteristics none

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

If naturalized, certificate No..... Date.....

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

2. MARITAL INFORMATION:

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

Applicant's initial C.M.

MARITAL INFORMATION-Continued

A. **Current Marriage** Date: ____ City, County and State: St. Lucia Island

Spouse's full name (Maiden) Eric Malfetta S.S. No. ____

Date of Birth ____ Place of Birth Bronx, NY

Resident address 2246 Driftwood Tide Ave (Street), Henderson (City), NV (State) 89052 (Zip)

Telephone: Residence ____ Business 702 296-4848

Spouse's employer Colliers Intl Occupation Commercial Broker

Address of employer 3960 Howard Hughes #150 (Street), Las Vegas (City), NV (State) 89169 (Zip)

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

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

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

Name	Street	City	State	Zip	Telephone
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address

B. Child Support Information:

Please mark the appropriate response:

☒ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial C.M.

FAMILY INFORMATION-Continued

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

Name.....

Address.....

Contact person.....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Frank Olivera		303 E. Washington St. Bensenville, IL 60106	Retired
Mother	Nereida Olivera		501 E. Jefferson Bensenville, IL 60106	Retired
Father-In-Law	John Molfetta		1767 Sebring Hills Henderson, NV 89052	Retired
Mother-in-Law	Bev Molfetta		1767 Sebring Hills Henderson, NV 89052	Retired

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

	Name (Maiden)	Birth Date	Address	Occupation
	Denise Larsen		1208 Ash Bensenville, IL 60106	United airlines
Spouse	Gary Larsen		1208 Ash Bensenville, IL 60106	unemployed
	Frank Olivera		1030 Whitepointe Dr. Lake in the Hills, IL 60156	unemployed
Spouse	none	—	n/A	n/A
	Mike Olivera		1 Joliet Elgin, IL 60177	Olivera designs
Spouse	Rivkah Olivera		1 Joliet Elgin, IL 60177	Separated
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Blackhawk Jr High	Bensenville, IL	1982-1983	Yes ☒ No ☐
High School	Fenton High School	Bensenville, IL	1984-1987	Yes ☒ No ☐
College University	n/A			Yes ☐ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any..... n/A .....

College or university where obtained..... n/A .....

Applicant's initial..... C.M. .....

5 MILITARY INFORMATION:

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

Branch.....Date of entry-active service.....

Date of separation.....Type of discharge.....

Rating at separation.....Serial number.....

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

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

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

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date

Applicant's initial.....CM.....

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

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

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

Name of Entity	Type of Entity	Approximate Date(s) of Lawsuit/Arbitration/Bankruptcy
Nocturna	Sleep center	10-4-05

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
11/05 – Present	2246 Driftwood Tide	Henderson, NV 89074	Clark
11/99 – 11/05	2358 Brockton Way,	Henderson, NV 89074	Clark
11/95 – 11/99	Irvine, California	CA,	Orange
1/84 – 11/95	501 E. Jefferson,	Bensenville, IL 60106	DuPage

Applicant's initial C.M.

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.

2001 – Present

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2001 – Present	Nocturna Sleep Centers 9077 S. Pecos Rd. #3700, Henderson, NV 89074	—
Title	**Description of Duties**	**Name of Supervisor**
Owner	Perform in lab diagnostic studies	me!

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2012 – 2013	Monnalisa Green Valley Pkwy Henderson, NV 89053	closed business
Title	**Description of Duties**	**Name of Supervisor**
Owner	kids clothing store	me!

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2010 – 2013	Arch Pedispa Eastern Ave Henderson, NV 89052	closed business
Title	**Description of Duties**	**Name of Supervisor**
Owner	Nail Salon	me!

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2000	American Home Patient LVINJ	opened new company
Title	**Description of Duties**	**Name of Supervisor**
Salesrep	Sell home O2 and CPAP Equip	Holly Orsulak

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1995 – 1999	Apria Healthcare Costa Mesa, CA	too much Travelling
Title Efficiency Expert	**Description of Duties** operations for DME company	**Name of Supervisor** Tony Dominico

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1997 – 1999	Abbey Home Health	Corp merger
Title	**Description of Duties**	**Name of Supervisor**
Admin Asst	Secretarial	Nanny

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1990 – 1997	UOP/Allied Signal	Better pay
Title	**Description of Duties**	**Name of Supervisor**
Graphics	Graphics Dept	Debra

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 C.M.

9. CHARACTER REFERENCES:

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

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Tara Knightly	Home	535 S. Arlington Hts Rd. Arlington Hts		60005		35
Employer The Room Place	Business	40 E. Rand Rd, Arlington Hts,				
Name Tracie Markes - Shaines	Home	2600 Lucky John Dr. Park City, UT 84060				35
Employer Self	Business	n/A				
Name Lara Tucker	Home	13310 Inwood Dr Woburn, MA 01801				25
Employer Apria	Business	n/A				
Name Jacquie Alger	Home	n/A military brat Just moved to Vegas				20
Employer Self	Business	n/A				
Name [redacted] Etola Berg	Home	10305 Calabasas Ave. Las Vegas, NV 89117				10
Employer Self	Business					

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

Box Number or Type of Depository	Location	City and State	Authorized Users

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

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

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

Manicurist, Henderson NV, 2010 - 2013

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

Applicant's initial C.M.

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

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

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

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

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

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

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

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

Date of photograph 8-17-15

Applicant's initial C.M.

STATE OF Nevada

ss.

COUNTY OF Clark

I, Christina Malfetta, 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.

Christina Malfetta
Original Signature of Applicant

Subscribed and Sworn to before me this 17th day of August 2015

Estrella Ponce
Notary Public

ESTRELLA PONCE
Notary Public State of Nevada
No. 11-3801-1
My appt. exp. Dec. 8, 2018
(seal)

Applicant's initial CM

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 MP 00468)

☐ 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: PAHRUMP MEDICAL SUPPLY, INC.

Physical Address: 1971 S. PAHRUMP VALLEY BLVD #D/PAHRUMP, NV 89048

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1971 S. PAHRUMP VALLEY BLVD #D

City: PAHRUMP State: NV Zip Code: 89048

Telephone: 775-751-4999 Fax: 775-751-4997

E-mail: PAHRUMPMS@GMAIL.COM Website: PAHRUMPMEDICALSUPPLY.COM

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9:00 to 5:00 Sat: BY APP to Sun: BY APP to Holidays: CLOSED to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: PAMELA K LEWIS

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

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

**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: PAMELA K LEWIS Telephone: 775-751-4999

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

MEDICARE	626975000l	
MEDICAID	100515701	

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

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

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

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

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☑

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☑

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☑

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

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☑

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

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

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

Pamela K Lewis

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

PAMELA K LEWIS

Print Name of Authorized Person

11-4-15

Date

Board Use Only	Received: _____	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: PAMELA K LEWIS

Business Name: PAHRUMP MEDICAL SUPPLY, INC.

Current Business Address: 1971 S. PAHRUMP VALLEY BLVD #D

City: PAHRUMP State: NV Zip: 89048

Telephone: 775-751-4999 Fax: 775-751-4997

SOLE OWNER

Include with the application for a sole owner

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 11-4-15

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

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

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

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

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

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

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

Application for DME, OXYGEN
Nature of MDEG

PAHRUMP MEDICAL SUPPLY, 1971 S. PAHRUMP VALLEY BLVD #D, PAHRUMP, NV 89048
Name and Address of Business for Which MDEG Administrator Is Requested

SAME AS ABOVE
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

CLARK (Last Name) | RUTH (First Name) | Ellen (Middle Name)

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

671 W. Kimberly (Present Residence Address-Street or RFD) | Pahrump (City) | NV 89060 (State/Zip)

1971 S. PAHRUMP VALLEY #D (Present Business Address) Dates 6/16/14-Present | PAHRUMP (City) | NV, 89048 (State/Zip)

FACILITY MANAGER (Present Position with the MDEG) Dates 6/16/14 - PRESENT

Phone: _____ _____ Fax: _____

Email address: PAHRUMPMS@GMAIL.COM

_____ (Date of Birth) | Montrose, San Juan, Colorado (Place of Birth (City, County, State))

59 (Age) | _____ (Social Security Number) | F (Sex)

Blue (Color of Eyes) | Brown (Color of Hair) | 200 (Weight) | 5'4" (Height)

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

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

If alien, registration No _____

If naturalized, certificate No _____ Date _____

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

EMPLOYMENT:

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

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
6/16/14- Present	PAHRUMP MEDICAL Supply	2000 HOURS
Title	**Description of Duties**	**Name of Supervisor**
Facility MANAGER	Billing, Sales, Filling	ARTUR KHACHATRYAN
2010-2013	Family Pharmacy	more than 3000
DME Manager	Customer Service, Billing ordering	Hwy 372 Pahrump NV 89049 Ali
1999- 2008	Option Care Pahrump Valley Blvd Pahrump NV 89048	more than 3000
Customer Service Clerk	Customer Service	Susan Bratty

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

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

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

a) Board Administrative Action: State: _____

b)

Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

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

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

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

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

.....

.....

.....

.....

.....

A

Date of photograph 11-6-15

I, Ruth CLARK, 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.

Ruth Clark
Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 11-4-15

GENERAL INSTRUCTIONS

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

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

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

Application for DURABLE MEDICAL EQUPMENT
Nature of License

PAHRUMP MEDICAL SUPPLY, INC. 1971 S. PAHRUMP VALLEY BLVD #D PAHRUMP, NV 89048
Name and Address of Establishment for Which License Is Requested

SAME AS ABOVE
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

LEWIS	PAMELA	KAY
Last Name	First Name	Middle Name

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

5251 GRAIN MILL RD	PAHRUMP,	NV 89061
Present Residence Address-Street or RFD	City	State/Zip

Dates

Present Business Address	City	State/Zip

VOLUNTEER — Dates 6/1/15 - pre

Occupation

Phone:
Residence
Business

Date of Birth — AUSTIN TX TRAVIS CO. — Place of Birth (City, County, State)

56 — Age — Social Security Number — Sex

GRN	GRAY	LIGHT	230	LRG	5'7"
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

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

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

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial PL

MARITAL INFORMATION-Continued

A. **Current Marriage** 1979 (Date) Harris Co. TX (City, County and St)

Spouse's full name (Maiden) Michael W. Lewis S.S. No.

Date of Birth Place of Birth Pasadena, Tx.

Resident address 5251 Grain Mill Rd (Street) Pahrump (City) NV (State) 89061 (Zip)

Telephone: Residence Business 775 751 4999

Spouse's employer O.M.V. Oil & Gas Occupation Superintendent

Address of employer Vienna, Astria (Street, City, State, Zip)

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

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

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

Name	Street	City	State	Zip	Telephone
N/A					

3. FAMILY INFORMATION:

A. Children and Dependents:

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

	Re

B. Child Support Information:

Please mark the appropriate response:

☑ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial PL.

FAMILY INFORMATION-Continued

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

Name .....

Address .....

Contact person .....

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	John Anderson Beaver		806 Arkansas So Hou TX 77587	Retired
Mother	Sylvia Doretha Beaver		806 Arkansas. So. Ho. TX 77587	Retired
Father-in-Law	Deceased			
Mother-in-Law	Deceased.			

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
Tammy Raventini		11315 Sagewood HOTX 77089	Underwriter
Spouse Donald Raventini		11315 Sagewood HOTX 77089	Disabled.
Cindy Landis		2201 Lily Glen Ct League City, TX 77573	Dental Office Manager
Spouse Joseph Landis		2201 Lily Glen Ct.	Superintendent
John Beaver		3404 N. Sandridge Hobbs, NM 88240	Superintendent
Spouse Jaska Beaver		3404 N. Sandridge Hobbs NM 88240	Counselor.
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	So. Ho. Elem.			Yes ☑ No ☐
High School	South Houston. High School.			Yes ☑ No ☐
College University				Yes ☑ No ☐
Other	San Jacinto. College. Beaumont Rd			Yes ☐ No ☐

Type of degree obtained, if any Assoc.

College or university where obtained San Jacinto. College. Houston. Tx 77089

Applicant's initial .....

5 MILITARY INFORMATION:

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

Branch..... Date of entry-active service.....

Date of separation..... Type of discharge.....

Rating at separation..... Serial number.....

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

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

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

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date

Applicant's initial.....

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

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

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

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

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

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
2004-2009	17504 Ponderosa Pines Dr.	Ho	TX 77090. Tx. Harris CO.
2002-2004	301 Lazy Hollow	League City,	TX 77573. Galveston CO.
	Lived Abroad Tunis Tunisia		

Applicant's initial: .....

8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
6/1/15-Present	1971. S. PAHRUMP VAlley BLVD #D PAHRUMP, NV 89048	Still with Company
Title	**Description of Duties**	**Name of Supervisor**
VolunteER	Customer Cervice, Submiting Billing, SAles	ARTUR Khachatryan
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1999-2005	13310 BEANER RD HUSTON TX 77089	HUSBAND WORKIND Abroad
Title	**Description of Duties**	**Name of Supervisor**
InSurance VERIFIER	Scheduling, Insurance Varification	DORI MEADOR
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**

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

Applicant's initial P. L.

9. **CHARACTER REFERENCES:**

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

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Jenny Thompson	Home 401 Oakland	League City	TX			30+
Employer CCISD.	Business Caterer for school district.					
Name Donna Black	Home 811 Romane Dr. Ho.	TX	77090			- 5
Employer Self Employed	Business Embroidery Bus.					
Name Mari Elliot	Home TX City	TX				15yr
Employer Bay Area Dental	Business Insurance Verifier					
Name Bernard Laffoon	Home Shreveport, La					8yrs.
Employer Retired -	Business					
Name	Home					
Employer	Business					

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

Box Number or Type of Depository	Location	City and State	Authorized Users

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

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

Yes ☑ No ☐
If yes, state type, where and years held

Liquor - TX 2 yrs.

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

Applicant's initial _____

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 ☐ Liquor

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

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

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

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

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

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

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

11-4-2015

Date of photograph 11-4-2015

Applicant's initial

STATE OF Nevada
ss.

COUNTY OF Nye

I, Pamela K Lewis, 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.

Pamela K Lewis
Original Signature of Applicant

Subscribed and Sworn to before me this 6th day of November, 2015

Debbie Haring
Notary Public

DEBBIE HARING
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 09-24-18
Certificate No: 10-3503-14

(seal)

Applicant's initial

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: Super Care Health

Physical Address: 3625 W. Tecd Ave, Suite #8, Las Vegas, NV 89118-6819

(This must be a business address, we can not issue a license to a home address)

Mailing Address: 8345 E. Firestone Blvd, Suite 210

City: Downey State: CA Zip Code: 90241

Telephone: 800-206-4880 Fax: 626-638-1404

E-mail: finance@supercare.com Website: www.supercarehealth.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9:00 to 5:00 Sat: on-call ~~to~~ Sun: on-call ~~to~~ Holidays: on-call ~~to~~

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Julie Sedgwick, RT

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

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

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Julie Sedgwick, RT Telephone: 702-224-2775

rev 01

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

SuperCare, Inc. - PTAN: 028280001 ; 028280004 ; 028280005 ; 028280006

Medi-Cal # PHA45943D

Hucek Enterprises, LLC - PTAN: G180990001 - Medi-Cal: 1740452168

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

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

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

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

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner, shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☒

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☒

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☒ No ☐

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

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☒

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

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

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

John Cassar

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

John Cassar — 12-8-2015

Print Name of Authorized Person — Date

Board Use Only	Received:	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: California.

Parent Company if any: Super Care, INC.

Corporation Name: Super Care, INC. dba Super Care Health.

Mailing Address: 8345 E. Firestone Blvd, Suite #210

City: Downey State: CA Zip: 90241

Telephone: 800-206-4880 Fax: 626-638-1404

Contact Person: John Cassar.

For any corporation non publicly traded, disclose the following:

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

a) John Cassar, 926 Santiago Ave., Long Beach, CA 90804
Name Address

b) Anthony Cassar, 7853 Valley Flores Dr, West Hills, CA 91304
Name Address

c) _____
Name Address

d) _____
Name Address

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

2) Provide the number of shares issued by the corporation. N/A

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

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

5) Provide a copy of the corporation's stock register evidencing the above information
Current Registration - Attached

SuperCareHealth

December 1, 2015

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

Reference: MDEG application
Page 3 Question #3
Personal History
Page 8 Question #16

To whom it may concern;

In response to question #3 on page 3 of the Medical Device Equipment and Gases application and the Personal History application question #16, page 8, SuperCare is on probation with the California State Board of Pharmacy.

More than 2 years ago an onsite pharmacy board inspection occurred and at that time our organization was sterile compounding. The issues included failure to maintain adequate or accurate records, violations of state statues and regulations, expired drugs in inventory, inadequate security mislabeling. All of these issues involved the compounding process. Not effectively meeting the USP 797 regulations, SuperCare ceased compounding and terminated the pharmacist in charge and the pharmacy technician involved.

As required by the California Board of Pharmacy, SuperCare retail and mail order pharmacy under goes quarterly inspections and self-assessments. Self-Assessments submitted to the board have been accepted and inspections completed have shown compliance.

Regards,

Susean Nichols, CHC

Susean Nichols, Corporate Compliance Officer

8345 East Firestone Blvd., Suite 210
Downey, CA 90241

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/8/15

GENERAL INSTRUCTIONS

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

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

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

Application for MDEG Home Respiratory Equipment & Services
Nature of License

SuperCare 3625 W. Teco Ave Ste 8 Las Vegas, NV 89118
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Cassar | John | [redacted] Louis
Last Name | First Name | Middle Name

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

926 Santiago Ave | Long Beach | CA 90804
Present Residence Address-Street or RFD | City | State/Zip

8345 Firestone Blvd Ste 210 | Dates 2002 - Present | Downey | CA 90241
Present Business Address | City | State/Zip

CEO | Dates 2008-Present
Occupation

Ottawa Canada | Business (800) 206-4880
Date of Birth | Place of Birth (City, County, State)

49 | Male
Age | Social Security Number | Sex

Hazel | Brown | Tan | 205 | | 6' 1"
Color of Eyes | Color of Hair | Complexion | Weight | Build | Height

Scars, tattoos or distinguishing marks and/or characteristics None

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

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

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

2. MARITAL INFORMATION:

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

Applicant's Initial.....

MARITAL INFORMATION-Continued

A. **Current Marriage** Date Santa Monica, Los Angeles, CA City, County and State

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

Date of Birth Place of Birth Long Beach, CA

Resident address 9216 Santiago Ave Long Beach CA 90804
Street City State Zip

Telephone: Residence Business (562) 307-5124

Spouse's employer Aflac Occupation Agent

Address of employer 1932 Wynnton Rd Columbus GA 31999
Street City State Zip

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

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

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

Name	Street	City	State	Zip	Telephone
N/A					

3. **FAMILY INFORMATION:**

A. **Children and Dependents:**

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

Residence Address

B. **Child Support Information:**

Please mark the appropriate response:

☑ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial

FAMILY INFORMATION-Continued

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

Name N/A

Address

Contact person

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Gabriel Cassar		3005 Rio Claro Hacienda Heights, CA	Pharmacist
Mother	Micheline Cassar		3005 Rio Claro Hacienda Heights, CA	retired
Father-In-Law	Ronald L. Hess		421 Tremont Long Beach, CA 90814	Pharmacist
Mother-in-Law	Judith A. Hess		330 Laurinda Long Beach, CA 90804	RN, Nurs

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

	Name (Maiden)	Birth Date	Address	Occupation
	Anthony Cassar		7853 Valley Flores Dr. West Hills	Pharmacist
Spouse	Maria Cassar		7853 Valley Flores Dr. West Hills	
	Michael Cassar		1911 Salto Dr. Hacienda Hts CA	IT
Spouse	Anne Cassar		1911 Salto Dr. Hacienda Hts, CA	Teacher
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Los Alamitos	Hac. Hts	76-78	Yes ☑ No ☐
High School	Los Altos	Hac Hts	80-84	Yes ☑ No ☐
College University	Loyola Marymount	Los Angeles	84-88	Yes ☑ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any B.A Business

College or university where obtained Loyola Marymount

Applicant's initial

5 MILITARY INFORMATION:

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

Branch..... Date of entry-active service.....

Date of separation..... Type of discharge.....

Rating at separation..... Serial number.....

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

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

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

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date
N/A				

Applicant's initial.....

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

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

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

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

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
1985-2000	2160 Plaza Del Amo	Torrance	CA
2001-2015	926 Santiago Ave	Long Beach	CA

Applicant's initial 

8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
January 2006	SuperCare Health 8345 Firestone Blvd Ste 210 Downey	Still there
Title	**Description of Duties**	**Name of Supervisor**
CEO	President	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
February 1995	Golden View Guest Home 3863 W Ramsey St. Banning CA	still there
Title	**Description of Duties**	**Name of Supervisor**
CEO	President	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
January 2004	GVGH 3863 W. Ramsey St. Banning CA	still there
Title	**Description of Duties**	**Name of Supervisor**
CEO	President	N/A
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
January 2004	Golden Meadows 3863 W. Ramsey St. Banning CA	still there
Title	**Description of Duties**	**Name of Supervisor**
CEO	President	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**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**

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

Applicant's initial ....

9. **CHARACTER REFERENCES:**

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

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name David White	Home 4217 Chestnut Ave	Long Beach	CA	90807		11
Employer AMC1 Inside	Business 12777 W. Jefferson Blvd	Los Angeles	CA			
Name Michael Sullivan	Home 293 St. Joseph Ave	Long Beach	CA	90803		7
Employer Sullivan Consulting	Business 523 W. 6th St.	L.A	CA	90014		
Name Howie Bloxam	Home 373 Marina Park Lane	Long Beach	CA	90803		
Employer Redbarn Pet Products	Business 3229 E. Spring St. Ste 310	Long Beach	CA	90806		
Name Peter Cassiano	Home 257 Argonne Ave	Long Beach	CA	90803		
Employer AEW Capital Management	Business 1001 S. Figueroa st. # 2150	Los Angeles	CA	90017		
Name Ron Biagi	Home N/A					8
Employer Biagi Mgmt. Group	Business 7 Beachcomber Dr.	Corona del Mar		92625		

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

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A			

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

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

Yes ☑ No ☐
If yes, state type, where and years held

Real Estate License, California, 1988-1995

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

Super Cars Inc. 16017 Valley Blvd L.A CA 91744
Partners: Tony Cassar
Agency: State of CA Corporation

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 ☐

State Board of Pharmacy in California

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 ☐

See attached

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

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

Father Surrendered License

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 ☒

A APH

ST

Date of photograph 12-8-2015

Applicant's initial

STATE OF California

ss.

COUNTY OF Los Angeles

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

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

Original Signature of Applicant

Subscribed and Sworn to before me this ..... day of

.....

.....

Notary Public

(seal)

Applicant's initial 

SuperCareHealth

December 1, 2015

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

Reference: MDEG application
Page 3 Question #3
Personal History
Page 8 Question #16

To whom it may concern;

In response to question #3 on page 3 of the Medical Device Equipment and Gases application and the Personal History application question #16, page 8, SuperCare is on probation with the California State Board of Pharmacy.

More than 2 years ago an onsite pharmacy board inspection occurred and at that time our organization was sterile compounding. The issues included failure to maintain adequate or accurate records, violations of state statues and regulations, expired drugs in inventory, inadequate security mislabeling. All of these issues involved the compounding process. Not effectively meeting the USP 797 regulations, SuperCare ceased compounding and terminated the pharmacist in charge and the pharmacy technician involved.

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Regards,

Susean Nichols, CHC

Susean Nichols, Corporate Compliance Officer

8345 East Firestone Blvd., Suite 210
Downey, CA 90241
800-206-4880 | supercarehealth.com

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/7/15

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.

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

Application for ~~MDEG Ho~~ MDEG Home Respiratory Equipment & Services
Nature of License

Super Care 3625 W. Teco Ave., Suite 8, Las Vegas, NV 89118
Name and Address of Establishment for Which License Is Requested

N/A
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

CASSAR | ANTHONY | JOHN
Last Name | First Name | Middle Name

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

~~5847 Vanna~~ 853 Valley Flores Dr. West Hills, CA 91301
Present Residence Address-Street or RFD | City | State/Zip

Present Business Address | City | State/Zip
Dates

Pharmacist. Dates 3/1/04 - current
Occupation

Phone: Residence 818-999-1063

Ontario
Ottawa, Ont., Canada Business
Place of Birth (City, County, State)

51
Age | Social Security Number | Sex

Hazel | Pepper/Gray | white | 185 | med. | 5'9"
Color of Eyes | Color of Hair | Complexion | Weight | Build | Height

Scars, tattoos or distinguishing marks and/or characteristics none

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

If naturalized, certificate No..... Date.....

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

2. MARITAL INFORMATION:

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

Applicant's initial

MARITAL INFORMATION-Continued

A. **Current Marriage** ..... Date ..... West Hills, CA City, County and State

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

Date of Birth ..... Place of Birth West Hills, CA

Resident address Same
Street City State Zip

Telephone: Residence ..... Business 818-889-3470

Spouse's employer Kanan Pharmacy Occupation Pharmacist

Address of employer 5847 Kanan Rd. Agoura Hills CA 91301
Street City State Zip

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

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

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

Name	Street	City	State	Zip	Telephone
N/A					

3. **FAMILY INFORMATION:**

A. **Children and Dependents:**

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

Name	Birth Date	Birth Place	Residence Address
Christopher	7/13/99	Whittier CA	Same
Nicole	2/11/03	Northridge, CA	Same

B. **Child Support Information:**

Please mark the appropriate response:

☒ I am not subject to a court order for the support of child.

☐ I am subject to a court order for the support of one or more children and am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

☐ I am subject to a court order for the support of one or more children and NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's initial .....

FAMILY INFORMATION-Continued

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

Name N/A.

Address

Contact person

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Gabriel Cassar	Tanta, Egypt	3005 Rio Claro, Hacienda Hts, CA 91745	Retired
Mother	Micheline Cassar	Montreal, Canada	3005 Rio Claro, Hacienda Hts, CA 91745	Retired
Father-in-Law	~~Frank~~ Angie Urso	Chicago, IL	25400 Prado De Las Bellota, Calabasas, CA 91302	
Mother-in-Law	Angie ~~Frank~~ Urso	Altavilla, Sicily, Italy	22754 Roscoe Blvd, West Hills, CA 91304	

D. Brothers and Sisters:

List names, residence addresses, dates of birth and most recent occupations of brothers and sisters and of their respective spouses.

Name (Maiden)	Birth Date	Address	Occupation
John Cassar	[illegible]	926 Santiago Ave, Long Beach, CA 90804	CEO
Spouse Carol A. Cassar (Hess)	[illegible]	926 Santiago Ave, Long Beach, CA 90804	
Michael Cassar	[illegible]	1911 Salto Dr Hacienda Hts, CA 91745	IT
Spouse Ann Cassar (	[illegible]	1911 Salto Dr Hacienda Hts, CA 91745	Teacher, Special Needs
Spouse			
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	Mesa Robles Elementary	Hacienda Hts, CA	9/75 - 6/81	Yes ☒ No ☐
High School	Los Altos H.S.	Hacienda Hts, CA	9/77 - 6/83	Yes ☒ No ☐
College University	Loyola Marymount University		8/84 - 6/88	Yes ☒ No ☐
Other	USC School of Pharmacy			Yes ☐ No ☐

Type of degree obtained, if any Bachelors Business Admin. & Doctor of Pharmacy

College or university where obtained LMU & USC Respectively

Applicant's initial

5 MILITARY INFORMATION:

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

Branch ..... Date of entry-active service .....

Date of separation ..... Type of discharge .....

Rating at separation ..... Serial number .....

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

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

County LA State CA Date registered Don't recall

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date
N/A				

Applicant's initial .....

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

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

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

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

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
7/99 - Present	7853 Valley Flores Dr.	West Hills,	CA

Applicant's initial .....

8. EMPLOYMENT:

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

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
5/17/83	Super Care 20171/2 S. Hacienda Blvd. Hacienda Hts, CA	went to College
Title	**Description of Duties**	**Name of Supervisor**
Technician	Typing Rxs	Grace Cassa
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
12/87	Super Care 16017 ~~Gale Ave Hacienda Hts~~,	City of Industry Went to school for Pharmacy
Title	**Description of Duties**	**Name of Supervisor**
VP Operations	Supervised Delivery, PTS, AR	Micheline Cassa
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1993	Norris Cancer Hospital	Different Job
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist, Intern	Typed, Filled Rx, Counseled pts.	Bob — ?
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
1994-1995	Omnicare Cerritos	Focusing on school
Title	**Description of Duties**	**Name of Supervisor**
Pharmacist Intern,	Filled Rx, E	Hani Tadros
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
8/1996	Super Care Inc.	Opened own business
Title	**Description of Duties**	**Name of Supervisor**
VP Ops.	Managed IT, PTS, Delivery Operations & Pharmacy staff	Micheline Cassa
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
3/2004	~~Kanan Pharmacy~~ 16017 Valley Blvd. Indus	
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
3/2004	Kanan Pharmacy 5847 Kanan Rd, Agoura CA 91301	still here
Title	**Description of Duties**	**Name of Supervisor**
CEO	Manage & Run business	N/A
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 KJC

9. CHARACTER REFERENCES:

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

Name of Where Employed	Street	City	State	Zip	Telephone	Years Known
Name Glen Ames	Home 7465 Zona Ave.	West Hills	CA			10
Employer NA	Business NA					
Name Susie Ngo	Home NA				8	15
Employer Super Cure	Business 8345 Firestone Blvd Ste 210	Downey	CA	90241		
Name Rina Tan	Home				264	15
Employer Super Cure	Business 8345 Firestone Blvd Ste 210	Downey	CA	90241		
Name Wendy Quinde	Home				84	7
Employer Super Cure	Business 8345 Firestone Blvd Ste 210	Downey	CA	90241		
Name Cassie Miller	Home					
Employer Golden Meadows	Business 35163 W Ramsey	Banning	CA	92220		8

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

Box Number or Type of Depository	Location	City and State	Authorized Users
N/A.			

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

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

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

CA - Pharmacist

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

Super Care - 16017 Valley Blvd., Industry CA 91748
Karan Pharmacy 5817 Karan Rd. Agoura Hills, CA 91301
with wife.

Applicant's initial

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

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

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

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 ☒

See attached

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

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

father surrendered pharmacist license.

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 12/8/15

Applicant's initial

STATE OF California

ss.

COUNTY OF Los Angeles

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

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

Original Signature of Applicant

Subscribed and Sworn to before me this ..... day of

.....

.....

Notary Public

(seal)

Applicant's initial .....

SuperCareHealth

December 1, 2015

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

Reference: MDEG application
Page 3 Question #3
Personal History
Page 8 Question #16

To whom it may concern;

In response to question #3 on page 3 of the Medical Device Equipment and Gases application and the Personal History application question #16, page 8, SuperCare is on probation with the California State Board of Pharmacy.

More than 2 years ago an onsite pharmacy board inspection occurred and at that time our organization was sterile compounding. The issues included failure to maintain adequate or accurate records, violations of state statues and regulations, expired drugs in inventory, inadequate security mislabeling. All of these issues involved the compounding process. Not effectively meeting the USP 797 regulations, SuperCare ceased compounding and terminated the pharmacist in charge and the pharmacy technician involved.

As required by the California Board of Pharmacy, SuperCare retail and mail order pharmacy under goes quarterly inspections and self-assessments. Self-Assessments submitted to the board have been accepted and inspections completed have shown compliance.

Regards,

Susean Nichols, CHC

Susean Nichols, Corporate Compliance Officer

8345 East Firestone Blvd., Suite 210
Downey, CA 90241

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 12/7/15

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

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

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

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

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

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

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

Application for Home Respiratory Equipment and Services.

Nature of MDEG

Super Care Health, 3625 W. Teco Ave, Suite #8, Las Vegas, NV 89118-6819

Name and Address of Business for Which MDEG Administrator is Requested

N/A

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Sedgwick (Last Name) | Julie (First Name) | Renee (Middle Name)

Julie Sedgwick-Brenner
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

152 Fratelli Ave | Las Vegas | NV 89183
Present Residence Address-Street or RFD | City | State/Zip

QMES LLC | Dates May 2014 Dec 2015 | Brooklyn | NY
Present Business Address | City | State/Zip

Super Care Health Administrator - R.T. | Dates Dec 2015
Present Position with the MDEG

Phone: 702-757-8855 Fax: _____

Email address: juliesedgwick@yahoo.com

_____ | San Diego, CA
Date of Birth | Place of Birth (City, County, State)

33 | _____ | F
Age | Social Security Number | Sex

Green | Blonde | 130 | 5'3.5"
Color of Eyes | Color of Hair | Weight | Height

Scars, tattoos or distinguishing marks and/or characteristics Key tattoo on left wrist, 2 hearts with crowns tattoo on shoulders

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

If alien, registration No N/A

If naturalized, certificate No_____ Date _____

Place_____(If naturalized, document must be verified.)

EMPLOYMENT:

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

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
5/14	Ultra Medical Supply / Ames	3000 + hrs
Title	Description of Duties	Name of Supervisor
Respiratory Therapist	CPAP/BiPAP Setup O2 setup	Avremi Metal
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
7/11 to 5/14	Wittgrove Bariatric at Scripps	3000 + hrs.
Title	Description of Duties	Name of Supervisor
Respiratory Therapist	Ventilation, CPAP/BiPAP	Dr. A. Wittgrove.
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
3/11 to 7/11	Carlsbad	1084 hrs.
Title	Description of Duties	Name of Supervisor
Respiratory Therapist	O2/CPAP/BiPAP setup	Michelle Dicrico.
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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

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

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

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

a) Board Administrative Action: State: N/A

b) Date: _____

Case Number: _____

c) Criminal Action: State: N/A

Date: _____

Case Number: _____

County: _____

Court: _____

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

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

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

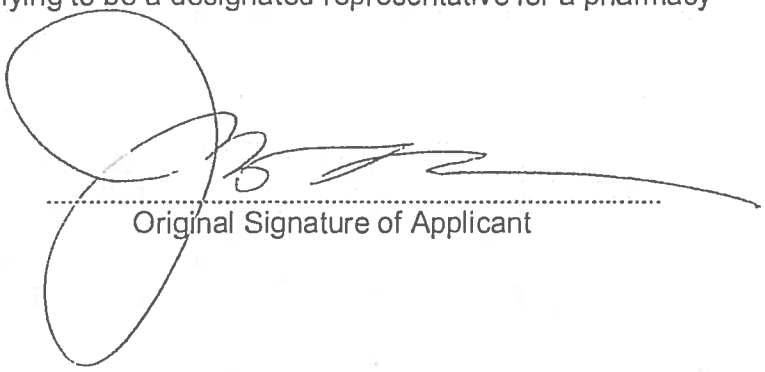
If you answer No to questions 4, 5 or 6 please provide a written letter of explanation

N/A

Date of photograph 12/7/15

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

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



Original Signature of Applicant

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Search

Licensee Details

Person Information	
Name:	Julie Renee SEDGWICK
Address:	152 Fratelli Ave Las Vegas NV 89183
Phone:	6198470823

License Information			
License Type:	Practitioner of Respiratory Care		
License Number:	RC2436	Status:	Active
Issue Date:	6/2/2014	Expiration Date:	6/30/2017

Scope of Practice

Scope of Practice: Respiratory Care

Education & Training

School:	Junipero Serra High School , San Diego , CA
Degree\Certificate:	High School Diploma
Date Enrolled:	
Date Graduated:	6/14/2000
Scope of Practice:	

School:	California College San Diego / San Diego , CA
Degree\Certificate:	Associate Science Degree
Date Enrolled:	10/1/2008
Date Graduated:	6/4/2010
Scope of Practice:	Practitioner of Respiratory Care

School:	California College San Diego / San Diego , CA
Degree\Certificate:	Bachelor of Science
Date Enrolled:	
Date Graduated:	11/4/2011
Scope of Practice:	

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