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: Children's Orthotics and Prosthetics LLC

Physical Address: 810 S. Durango Drive, Suite 100, Las Vegas, NV 89145

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

Mailing Address: 810 S. Durango Drive, Suite 100

City: Las Vegas State: NV Zip Code: 89145

Telephone: 702-932-1300 Fax: 702-848-4990

E-mail: alicia@childrensop.com Website: www.childrensop.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8am to 5pm Tue: 8am to 5pm Wed: 8am to 5pm Thu: 10am to 7pm

Fri: 8am to 5pm Sat: 9am to 12pm Sun: CLOSED to Holidays: 8am to 5pm

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Alicia Laurie Purdum

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: _____ Telephone: _____

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

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: Alicia Laurie Purdum
☐ 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.

Alicia L Purdum

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

ALICIA L. PURDUM

Print Name of Authorized Person

9/12/2017

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: Alicia Laurie Purdum

Business Name: Childrens Orthotics and Prosthetics LLC

Current Business Address: 810 S. Durango Drive, Suite 100

City: Las Vegas State: NV Zip: 89145

Telephone: 702-932-1300 Fax: 702-848-4990

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 9/12/2017

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 Orthotics and Prosthetics - MDEG

Nature of MDEG

Children's Orthotics and Prosthetics LLC, 810 S. Durango Dr., Ste 100, Las Vegas, NV 89145

Name and Address of Business for Which MDEG Administrator Is Requested

Children's Orthotics and Prosthetics LLC

If applicable, Name Under Which It Is Now Operated

AJP

1. PERSONAL INFORMATION:

Purdum	Alicia	Laurie
Last Name	First Name	Middle Name

Alicia Laurie Lynch, Alicia Laurie Marquardson
Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Vintage Wine Ave	Las Vegas,	NV 89148
Present Residence Address-Street or RFD	City	State/Zip

810 S. Durango Dr Suite 100 ~~Dates~~	Las Vegas,	NV 89145
Present Business Address	City	State/Zip

Owner / Practicioner Dates 06/07/2017 – Present
Present Position with the MDEG

Phone: 702-510-5532 Fax: 702-848-4990

Email address: alicia@childrensop.com

	Seattle, King, WA
Date of Birth	Place of Birth (City, County, State)

44		Female
Age	Social Security Number	Sex

Blue	Brown	200	5'11"
Color of Eyes	Color of Hair	Weight	Height

Scars, tattoos or distinguishing marks and/or characteristics N/A
(I often wear glasses)

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

If alien, registration No N/A

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

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

ALP

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.

01/2016 - 08/2017	Orthopedic Motion, Inc. 3233 W. Charleston Blvd #111, LV, NV 89102	3,293
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist/prosthetist	Evaluate and treat patients for orthoses and prostheses	Brittany Stryker
Title	Description of Duties	Name of Supervisor
08/2015 - 01/2016	Prosthetic Center of Excellence 400 Shadow Lane #110, LV, NV 89106	780
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist/Prosthetist	Evaluate and treat patients for orthoses and prostheses	Michael Straughn
Title	Description of Duties	Name of Supervisor
07/2004 - 11/2005	Prosthetic Center of Excellence 400 Shadow Lane #110, LV, NV 89106	2860
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist/Prosthetist	Evaluate and treat patients for orthoses and prostheses	Michael Straughn
Title	Description of Duties	Name of Supervisor
04/2002 - 11/2003	Hanger Prosthetics and Orthotics 7250 Peak Dr., Las Vegas, NV 89128	3,293
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist/Prosthetist	Prosthetic Residency	Ed Sisson
Title	Description of Duties	Name of Supervisor
11/2001 - 4/2002	Hanger Prosthetics and Orthotics Great Falls, Montana	867
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist/Manager	Practitioner and Office Manager	Graham Hurley
Title	Description of Duties	Name of Supervisor
8/2000 - 11/2001	Hanger Prosthetics and Orthotics Reno, Nevada	2600
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Orthotist	Orthotic Residency	Jay Murray
Title	Description of Duties	Name of Supervisor

AJP

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

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

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

a) Board Administrative Action:
b)

State: N/A

Date: N/A

Case Number: N/A

c) Criminal Action:

State: N/A

Date: N/A

Case Number: N/A

County: N/A

Court: N/A

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

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

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

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

N/A

Date of photograph 09/12/2017

I, Alicia Laurie Purdum, 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.

Alicia Laurie Purdum

Original Signature of Applicant

NEVADA STATE BOARD OF PHARMACY

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

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

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

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

Application must be printed legibly or typed

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

☒ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change

(Please provide current license number if making changes: MP or MW _____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6

☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☒ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Las Vegas Medical Store

Physical Address: 4527 W. Sahara Ave. Las Vegas, NV 89102

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

Mailing Address: 4527 W. Sahara Ave

City: Las Vegas State: NV Zip Code: 89102

Telephone: 702-803-1365 Fax: 702-920-8366

E-mail: info@lasvegasmedicalstore.com Website: Lasvegasmedicalstore.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 10am to 5pm Tue: 10am to 5pm Wed: 10am to 5pm Thu: 10am to 5pm

Fri: 10am to 5pm Sat: By appointment to ____ Sun: By Appointment to ____ Holidays: ____ to Closed.

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: LaToyria Oliphant

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: LaToyria Oliphant Telephone: (314) 732-9421

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: Ana P. Gonzalez

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

Armenak Muradyan
Print Name of Authorized Person

9-6-2017
Date

Board Use Only	Received: _____	Amount: _____

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: N/A

Parent Company if any: _____

Corporation Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

License Contact Person: _____

Ownership Information – Complete Section 1 or 2

Do not use N/A in this section – Section 1 or 2 must be completed.

Section 1: List the corporations four largest shareholders:
(Name and percentage of ownership)

1. Armenak Muradyan %: 100
2. _____ %: _____
3. _____ %: _____
4. _____ %: _____

Section 2: If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: _____

Registration number issued: _____

Stock Exchange: _____

Include with the application for a publicly traded corporation

List of officers and directors.

Certificate of Corporate status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Armenak Muradyan

Business Name: Las Vegas Medical Store

Current Business Address: 4527 W. Sahara Ave

City: Las Vegas State: NV Zip: 89102

Telephone: 702-803-1365 Fax: 702-920-8366

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 9.4.17

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 Latoyria Oliphant
Nature of MDEG

4527 W. Sahara Ave Las Vegas, NV 89102
Name and Address of Business for Which MDEG Administrator Is Requested

Las Vegas Medical Store
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Oliphant — Last Name
Latoyria — First Name
Shiense — Middle Name

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

Present Residence Address-Street or RFD: Acropolis Ave — City: North Las Vegas — State/Zip: NV 89031

Present Business Address: 4527 W. Sahara Ave — Dates — City: Las Vegas, — State/Zip: NV 89102

Present Position with the MDEG: Admin — Dates

Phone: 314-732-9421 — Fax:

Email address: traboogie@gmail.com

Date of Birth — Place of Birth (City, County, State): Saint Louis, Missouri

Age: 34 — Social Security Number — Sex: Female

Color of Eyes: dark brown — Color of Hair: dark brown — Weight: 145 — Height: 4'11

Scars, tattoos or distinguishing marks and/or characteristics: leg tattoos on left leg, right upper arm & left upper arm tattoo

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
6/12/2017	Comfort Care - 7477 West Lake Mead Blvd 89128	300
Title	**Description of Duties**	**Name of Supervisor**
Medical office supervisor	staffing, payroll, schedules	Robin Scmela
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
5/23/2008 - 6/7/2017	4126 seven Hills Dr 89033 Alliance In Home Health care	9,600
Title	**Description of Duties**	**Name of Supervisor**
Medical office Manager	Payroll, schedules, billing insurance, timesheets staffing, work hand & hand with nurses	Zondra Jones
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
12/ 4/ 2003 - 2007	Walgreens 8000 St. Rose Rock Rd	3,840
Title	**Description of Duties**	**Name of Supervisor**
Pharmacy Tech	inventory, filling prescriptions typing in prescriptions work with medical equipment & prescriptions	
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
4/2007 - 5/2008	Walmart Pharmacy	3,000
Title	**Description of Duties**	**Name of Supervisor**
	inventory, filling prescriptions trans in prescription, worked with medical equipment	Chris
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: _____

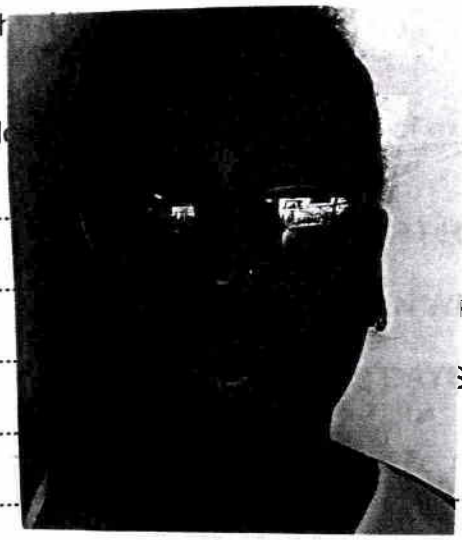
Court: _____

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 th during its normal operating hours? Yes ☑ No ☐

If you answer No to questions 4, 5 or 6 pl planation.



OTOGRAPH

THIN LAST

S HERE

09.04.2017

I, Latoya Lee Oliphant, 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.

Latoya Lee Oliphant

Original Signature of Applicant

12pm -

Latoyria Oliphant

Medical Administrative Manager - Alliance In Home Care Service

North Las Vegas, NV 89031
latoyriaoliphant7_cnw@indeedemail.com ·

To be able to excel in the medical field while applying what i know. I would like the opportunity to work hands on in a medical facility.
Authorized to work in the US for any employer

WORK EXPERIENCE

Medical administrator Manager

Alliance In Home Care Service - St. Louis, MO - 2007-04 - Present

I am responsible for the overall operation of the medical office. I also staff aides with clients

• Demonstrated proficiency with staffing aides with clients. Making sure that the aide will be able to accommodate the needs of the client.
• Answering the phone on the first ring or before the third ring. Making sure that all client and aides files are in order and neatly organized.
• Handles all payroll duties such as calculating all of the hours that the aides work on their particular client. Putting hours worked on a spread sheet and forwarding information to payroll department.
• Preparing schedules for the aides.
Staffing Veteran cases, preparing files
Prepares Schedules for in home and veteran clients and aides.
Billing for the in home clients
Staff nurses with new clients
Set up files
Write up DA'5
Write up 80%
Interviews
Orientations
Etc

Pharmacy Technician

Walgreens - St. Louis, MO - 2001-12 - 2007-01

Not only did I act as a cashier or clerk that managed money, but I answer the telephone, stock shelves and perform other administrative duties.
• Setting up and maintaining patient records, handling insurance claims and handling supplies.
Typed and filled prescriptions
Did prior authorization on insurance
Called physicians for customer/patients refills
Inventory
Worked side by side with the pharmacist

Substitute Teacher

YWCA - Overland, MO - 2000-04 - 2003-12

Under the direction of the Youth and Family Director, the Pre-K Instructor supervises groups of children and implements YMCA activities.
Conducts and organizes class activities. Follows specific YMCA Standard Operating

EDUCATION

Bachelor's in human service in Human service/minor sociology and criminal justice

Columbia College - St. Louis, MO
2015 - 2018

Associate in Medical Administrative Assistant/dental Assistance

Everest College - St. Louis, MO
2012 - 2013

Certification in Clinical laboratory assistant with phlebotomy

Saint Louis school of phlebotomy - St. Louis, MO

SKILLS

Pharmacy tech, Aba para professional, EKG, Vital sign, Venipuncture, Collecting specimen, Finger sticks

CERTIFICATIONS/LICENSES

Pharmacy Technician

2003-12 - 2007-09
Pht

ADDITIONAL INFORMATION

I am currently working on receiving my bachelors degree in human service and psychology with a continuation to work towards my masters. I am also minoring in sociology and criminal justice. I have worked hand and hand with children and adults with mental illness and disabilities. I also have experience in counseling