

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: Ascend Medical Products, Inc.

Physical Address: 195 Hwy 50, Suite 201 Zephyr Cove NV 89448
(This must be a business address. we can not issue a license to a home address!)

Mailing Address: 195 Hwy 50, Suite 201 PO Box 11127

City: Zephyr Cove State: Nevada Zip Code: 89448

Telephone: 775-461-1008 Fax: 775-335-0165

E-mail: zdarov1@yahoo.com Website: www.ascendmedicalproducts.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:00am to 5:00pm Tue: 8:00am to 5:00pm Wed: 8:00am to 5:00pm Thu: 8:00am to 5:00pm

Fri: 8:00am to 5:00pm Sat: _____ to _____ Sun: _____ to _____ Holidays: _____ to _____

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Richard Rappaport

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

- | | |
|--|---|
| <input type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | <input type="checkbox"/> Other: <u>Bracing, Post Surgical devices, etc, Bone growth Stimulators</u> |

**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: Richard Rappaport Telephone: 813-220-6137

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.

- NO
- Practitioner Name: _____
 - Advanced Practitioner of Nursing Name: _____
 - Physician's Assistant Name: _____
 - Physical Therapist Name: _____
 - Occupational Therapist Name: _____
 - Registered Nurse Name: _____
 - Respiratory Therapist Name: _____

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



APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

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

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

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

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

Richard Rappaport

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

Richard Rappaport
Print Name of Authorized Person

8/7/17
Date

Board Use Only	Received: _____	Amount: <u>\$ 500.00</u>
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APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICLY TRADED CORPORATION

State of Incorporation: NV
 Parent Company if any: N/A
 Corporation Name: Ascend Medical Products, Inc.
 Mailing Address: 195 Hwy 50, Ste 201, PO Box 11127
 City: Zephyr Cove State: NV Zip: 89448
 Telephone: 775-461-3008 Fax: 775-335-0165
 Contact Person: Richard Rappaport

For any corporation non publicly traded, disclose the following:

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

- a) Richard Rappaport, 3301 Bayshore Blvd, #2006, Tampa, FL 33629
 Tampa, FL 33629 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. 10,000
- 3) What was the price paid per share? 0.00
- 4) What date did the corporation actually receive the cash assets? 8/10/17
- 5) Provide a copy of the corporation's stock register evidencing the above information

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 8/7/7

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 hereon 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 License
Nature of License
Ascend Medical Products, Inc.
Name and Address of Establishment for Which License is Requested
If applicable, Name Under Which it is Now Operated

1. PERSONAL INFORMATION:

Rappaport Richard
Last Name First Name Middle Name

Aliases, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Bayshore Blvd. #2006 Tampa FL 33629
Present Residence Address-Street or RFD City State/Zip

3301 Bayshore Blvd. #2006 Dates
Present Business Address City State/Zip

CEO Dates
Occupation Phone Residence Business 775-461-1008

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

75 Social Security Number M
Age Sex

brown brown medium 160 lbs medium 5'9"
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 RR Page 1

MARITAL INFORMATION-Continued

N/A

A. **Current Marriage**.....

Spouse's full name (Maiden)..... Date..... City, County and State..... 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

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

Name	Street	City	State	Zip	Telephone

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
Dayna Titus		Queens NY	W. Woodbury Pleasanton CA 94566
Brian Rappaport		Marlboro, NJ	n Heath Old Bridge NJ 07747

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 RR

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			
Mother			
Father-in-Law			
Mother-in-Law			

D. Brothers and Sisters:

N/A

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

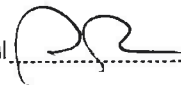
Name (Maiden)	Birth Date	Address	Occupation
Spouse			
Spouse			
Spouse			
Spouse			

4. EDUCATION:

Name of School	Location	Dates Attended	Graduate
Grammar School	Eisenhower Elementary, Ny Ny	1955-1955	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
High School	Public School #109, Ny, NY	1955-1959	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
College University	Syracuse University, Syracuse NY	1959-1963	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Other			Yes <input type="checkbox"/> No <input type="checkbox"/>

Type of degree obtained, if any B.S., Business

College or university where obtained Syracuse University

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 NY State NY Date registered 1959

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 RR Page 4

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
1/84-present	Bayshore Blvd #2006	Tampa	FL 33629

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
2/97	Panther Medical, 405 N Reo #102 Tampa FL 33609	N/A
Title	Description of Duties	Name of Supervisor
President	oversee operations	N/A
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
1/84-1/97	Rehab Systems 1200 Kennedy Blvd Tampa FL 33609	Company closed
Title	Description of Duties	Name of Supervisor
President	oversee operations	N/A
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2/75-1/84	Mentor Corp, Minneapolis MN	laid off
Title	Description of Duties	Name of Supervisor
Sales Director	oversee sales	Chris Smith
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
4/64-2/75	Baxter, Inc NY NY	laid off
Title	Description of Duties	Name of Supervisor
Sales Rep	Sell medical devices	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 RR

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 <u>Helen Gilbert</u>	Home	<u>Bayshore Blvd #4008 Tampa FL</u>			<u>33629</u>	<u>10 yrs</u>
Employer <u>N/A</u>	Business	<u>N/A</u>				
Name <u>Rochelle Gross</u>	Home	<u>Hyde Park, Tampa FL</u>			<u>33629</u>	<u>-12 yrs</u>
Employer <u>N/A</u>	Business	<u>N/A</u>				
Name <u>Cindy Spahn</u>	Home	<u>N Trail Drive, Tampa FL</u>			<u>33609</u>	<u>-10 yrs</u>
Employer <u>Self</u>	Business	<u>Stockbroker</u>				
Name <u>Russell Robinson</u>	Home	<u>N. 42nd St, Ny, Ny</u>			<u>10012</u>	<u>-9 yrs</u>
Employer <u>JNF</u>	Business	<u>philanthropy</u>				
Name <u>Michelle Banducci</u>	Home	<u>- Gloria St, Pleasanton CA</u>			<u>94566</u>	<u>-7 yrs</u>
Employer <u>Self</u>	Business	<u>physician</u>				

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.

DME - North Carolina - Panther Medical
1/2015 405 N Reo #102 Tampa FL
33609

Applicant's initial RD

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

North Carolina for DME license

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

8/2/17

Applicant's initial

RR