

NEVADA STATE BOARD OF PHARMACY
 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR NEVADA PHARMACY LICENSE

\$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.

<input type="checkbox"/> New Pharmacy	<input checked="" type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH_NO <u>2759</u>)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7,8a,8b	<input checked="" type="checkbox"/> Partnership - Pages 1,2,5,7,8a,8b
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: KENS PROFESSIONAL COMPOUNDING PHARMACY

Physical Address: 2202 W. CHARLESTON Blvd STE #13

Mailing Address: 2202 W. CHARLESTON Blvd STE #13

City: LAS VEGAS State: NV Zip Code: 89102

Telephone: 702-384-3784 Fax: 702-383-3796

Toll Free Number: N/A

E-mail: N/A Website: N/A

Managing Pharmacist: KENNETH HEATON License Number: 11495

Hours of Operation:

Monday thru Friday	<u>9:00</u> am	<u>5:30</u> pm	Saturday	<u>10:00</u> am	<u>2:00</u> pm
Sunday	<u>CLOSED</u> am	<u>CLOSED</u> pm	24 Hours	<u>N/A</u>	

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail	<input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> Parenteral
<input type="checkbox"/> Internet	<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Nuclear	<input type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> Out of State	<input type="checkbox"/> Mail Service
<input type="checkbox"/> Ambulatory Surgery Center	<input checked="" type="checkbox"/> Long Term Care

APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

- 1) Has the corporation, any owner(s), 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 pharmacy 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

CAMERON FRENCH
Print Name of Authorized Person

03/13/17
Date

Board Use Only

Received: _____ Amount: \$500.00

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

List names of 4 largest partners and percentage of ownership:

Name: PEGRAM HEALTH CORP. %: 100
Name: _____ %: _____
Name: _____ %: _____
Name: _____ %: _____

Partnership Name: CHARLESTON PHARMACY LP
Mailing Address: 2202 W. CHARLESTON Blvd STE #13
City: LAS VEGAS State: NV Zip Code: 89102
Telephone: 702-384-3784 Fax: 702-383-3796
Contact Person: CAMERON FRENCH

List any physician shareholders and percentage of ownership.

Name: CAMERON FRENCH %: 10
Name: N/A %: _____

PARTNERSHIP

Include with the application for a partnership

Designated representative form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses.*

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an examination on law **prior** to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

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

STATEMENT OF RESPONSIBILITY - Pharmacy
For Corporations, Partnership or Sole Owners


I, CAMERON FRENCH

Responsible Person of CHARLESTON PHARMACY LP, DBA KENE PROFESSIONAL Compounding Pharmacy
hereby acknowledge and understand that in addition to the corporation's, any owner(s),
shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy
law that may occur in a pharmacy owned or operated by said company.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s)
or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a
pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s)
or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision
of any local, state or federal laws or regulations pertaining to the practice of pharmacy or
operation of a pharmacy in Nevada.

I further acknowledge and understand that upon the change of managing pharmacist in the
pharmacy, the owners must assure that an accountability audit of all controlled substances shall
be performed jointly by the departing managing pharmacist and the new managing pharmacist.


Original Signature, no stamps or copies

03/13/17
Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: KENNETH HEATON

License #: 11495

Pharmacy Name: KEWS PROFESSIONAL COMPENSING PHARMACY

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. been the subject of an administrative action whether completed or pending in any state?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If you marked YES to any of the numbered questions above, please include the following information		
Board Administrative Action:	State: <u>NV</u>	Date: <u>01/18/2012</u> Case #: <u>10-078A RPH-S</u>
And/or Criminal Action:	State: _____	Date: _____ Case #: _____
County: _____	_____	Court: _____

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,

v. Petitioner,

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND ORDER

KENNETH E. HEATON, R.PH.
Certificate of Registration #11495,

Case No. 10-078A-RPH-S

JEFFREY C. PETERSEN, R.PH.
Certificate of Registration #08402,

Case No. 10-078B-RPH-S

WAL-MART #10-2592,
Certificate of Registration #PH01216,
Respondents.

Case No. 10-078-PH-S

THIS MATTER was heard by the Nevada State Board of Pharmacy (hereinafter Board) at its regular meeting on January 18, 2012 in Las Vegas, Nevada. The Board was represented by Carolyn J. Cramer, General Counsel to the Board. Respondent Heaton was represented by represented by Robert C. Graham, Esq. Respondent Petersen represented himself. Respondent Wal-Mart #10-2592 was represented by Hal Taylor, Esq. Based on the presentations of the parties and the public records in the possession and control of the Board, the Board issues the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

1. At hearing, the parties stipulated to the admission of all Exhibits. Respondents Heaton and Wal-Mart were not contesting the charges. Respondent Petersen was contesting the case. Board Staff presented the testimony of Sharon Mashburn, the complainant in this matter, and Danny Garcia, Board investigator.

2. Mr. Garcia testified to the Exhibits that he was provided during Staff's investigation into the matter. Staff presented Exhibits 1 through 22. Mr. Garcia testified that during his interview of Respondent Petersen at all times Mr. Petersen denied that he had a conversation with Mrs. Mashburn questioning her medication. Mr. Garcia testified that Mrs. Mashburn was adamant about speaking with Respondent Petersen regarding the adverse reaction she was experiencing regarding the medication she was taking. Mr. Garcia testified that at all times Respondent Heaton acknowledged that he missed the input error that had occurred regarding the four prescriptions that had been dispensed to Mrs. Mashburn with her name on them, however with a different physicians name, that should have been dispensed to another patient. Mr. Garcia testified that Respondent Heaton was frustrated that Ms. Mashburn had to be counseled on every prescription that was new to her or a refill as per Wal-Mart's policy. In this case, Mr. Garcia testified that Mrs. Mashburn unwittingly refused counseling when she picked up her medications, believing that all of the medications that were being dispensed to her she had previously taken. Ms. Mashburn was unaware that four of the medications in the bag were new and not intended for her.

3. Mrs. Mashburn testified that she experienced severe anger, raging behavior, memory problems and blackouts after she began taking the medications she was dispensed. Mrs. Mashburn testified that she contacted the pharmacy and questioned the medication she had received with an unfamiliar doctor's name on the labels. Mrs. Mashburn testified that she had been assured that the medication she was taking was correct. Mrs. Mashburn testified that when she saw her physician and questioned the medication her physician determined that she had been taking someone else medication that had not been prescribed for her.

4. Respondent Heaton testified that he did not notice the difference in the doctors on the prescriptions that were before him when he was verifying the prescriptions and when it was time to counsel Mrs. Mashburn on her medications.

5. Respondent Petersen testified that he did not speak to Mrs. Mashburn when she called with questions on her prescriptions.

6. Respondent Wal-Mart made a Motion to Dismiss the charges against it as plead in the Fourth Cause of Action as there were no facts that Wal-Mart had done anything incorrectly. Board Staff did not oppose and the Motion to Dismiss was granted.

7. Respondent Petersen made a Motion to Dismiss the charges against him as plead in the Third Cause of Action. Board Staff opposed, however the Board found that Mr. Petersen was not guilty of the charges and dismissed the Third Cause of Action against Mr. Petersen.

8. Respondent Heaton made a Motion to Dismiss the Second Cause of Action as pled because Mrs. Mashburn testified that she refused counseling. Board Staff opposed, as the testimony by Mrs. Mashburn reflected that she believed that she had previously taken the medications she was being dispensed, and was unaware of the four medications in the bag were not hers. The Board found Respondent Heaton was not guilty of the charge of failure to counsel and dismissed the Second Cause of Action.

CONCLUSIONS OF LAW

1. The Nevada State Board of Pharmacy has jurisdiction over this matter because Respondent Heaton is a pharmacist licensed by the Board.

2. By dispensing Patient F's prescriptions for Hydralazine 25 mg. tablets, Carvedilol 6.25 tablets, Gemfibrozil 600 mg. tablets and Pravastatin 40 mg tablets to

Ms. Mashburn causing her to ingest medications that were not prescribed for her, Mr. Heaton violated NRS 639.210(4) and NAC 639.945(1)(i).

ORDER


Based upon the foregoing, the Board hereby orders the following:

1. Mr. Heaton shall pay the Board's investigation and attorney's fees of \$1,152.44 and the Board's administrative fee of \$295.00, for a total of \$1,447.44 by cashier's check or certified check or money order made payable to "Nevada State Board of Pharmacy" to be received by the Board's Reno office within 90 days of the effective date of this Order.
2. Mr. Heaton shall pay a fine of \$1,000.00 by cashier's or certified check or money order made payable to "State of Nevada, Office of the Treasurer" to be received by the Board's Reno office within 90 days of the effective date of this Order.
3. Within 10 days Mr. Heaton shall contact the Your Success Rx consultant to enroll in its pharmacist remediation program (hereinafter "the program") according to the terms and conditions imposed by the program.
 - a. Mr. Heaton shall cooperate fully and genuinely with the needs, demands, and requirements of the program.
 - b. Mr. Heaton shall inform and assure that his employing pharmacy is made aware of his participation in the program and that his employing pharmacy accommodates the program's needs regarding Mr. Heaton's time needed to participate in the program and the program's potential need to be present in the employing pharmacy.
 - c. Mr. Heaton shall pay the entire cost of his participation in the program.

d. When Mr. Heaton has completed the program, the program shall submit to Board Staff a final report regarding Mr. Heaton's participation in the program. Board Staff will set a meeting with Mr. Heaton and the Your Success Rx program administrator to review and discuss the report.

4. The failure by Mr. Heaton to comply with any term in this order shall result in the immediate suspension of his license and will also result in further discipline, up to and including revocation of the his license.

Signed this 14th day of February, 2012.



Beth Foster, President
Nevada State Board of Pharmacy

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(Please provide current license number if making changes: PH _____)			

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

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: PPD Development, LP

Physical Address: 8285 W. Arby Ave, Suite 331

Mailing Address: SAME

City: Las Vegas State: NV Zip Code: 89113

Telephone: +1-702-963-1600 Fax: N/A

Toll Free Number: N/A

E-mail: Elaine.Watkins@ppdi.com Website: www.ppdi.com

Managing Pharmacist: Lee (Xiaoli) Sun License Number: 19052

Hours of Operation: Open weekends as needed to support ongoing phase 1 clinical trials

Monday thru Friday 8 am 4 pm Saturday am pm

Sunday am pm 24 Hours

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail	<input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Hospital (# beds _____)	<input type="checkbox"/> Parenteral
<input type="checkbox"/> Internet	<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Nuclear	<input type="checkbox"/> Outpatient/Discharge
<input type="checkbox"/> Out of State	<input type="checkbox"/> Mail Service
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Long Term Care

96198

APPLICATION FOR NEVADA PHARMACY LICENSE

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Within the last five (5) years:

- 1) Has the corporation, any owner(s), 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 pharmacy 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.

Elaine Watkins, D.O.
Original Signature of Person Authorized to Submit Application, no copies or stamps

Elaine Watkins, D.O. 3/15/2017
Print Name of Authorized Person Date

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

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

List names of 4 largest partners and percentage of ownership:

Name: PPD Holdings, LLC %: 99.9
Name: PPD GP, LLC %: 0.01
Name: _____ %: _____
Name: _____ %: _____

Partnership Name: PPD Development, L.P.

Mailing Address: 929 North Front Street

City: Wilmington State: NC Zip Code: 28401

Telephone: 910-251-0081 Fax: 910-762-5820

Contact Person: Lisa Hornick

List any physician shareholders and percentage of ownership.

Name: _____ %: _____
Name: _____ %: _____

PARTNERSHIP

N/A per Candy at the NV BOP because both partners are Limited Liability Partners. See attached letter

Include with the application for a partnership

Designated representative form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an examination on law **prior** to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

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

STATEMENT OF RESPONSIBILITY - Pharmacy
For Corporations, Partnership or Sole Owners

Elaine Watkins

Responsible Person of PPD Development, L.P.

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said company.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy or operation of a pharmacy in Nevada.

I further acknowledge and understand that upon the change of managing pharmacist in the pharmacy, the owners must assure that an accountability audit of all controlled substances shall be performed jointly by the departing managing pharmacist and the new managing pharmacist.

Elaine Watkins
Original Signature, no stamps or copies

3/15/2017
Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Lee (Xiaoli) Sun

License #: 19052

Pharmacy Name: PPD Development, LP

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. been the subject of an administrative action whether completed or pending in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If you marked YES to any of the numbered questions above, please include the following information		
Board Administrative Action: State: _____ Date: _____ Case #: _____		
And/or Criminal Action: State: _____ Date: _____ Case #: _____ County: _____ Court: _____		

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 431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
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Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: _____, Specialty Care RX _____

Physical Address: 801 South Rancho Dr. Suite D-1A

Mailing Address: 801 South Rancho Dr. Suite D-1A

City: Las Vegas State: Nevada Zip Code: 89106

Telephone: (702) 790-4404 Fax: (702) 790-4406

Toll Free Number: (844) 237-3377

E-mail: info@myscrx.com Website: myscrx.com

Managing Pharmacist: Clare-lanie Guerrero Macaraeg License Number: 19507

Hours of Operation:

Monday thru Friday 9:00 am 5:00 pm Saturday ^{OFF} _____ am _____ pm
 Sunday ^{off} _____ am _____ pm 24 Hours On-Call

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input type="checkbox"/> Nuclear <input type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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96201

APPLICATION FOR NEVADA PHARMACY LICENSE

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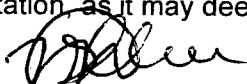
Within the last five (5) years:

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

Clare-lanie Macaraeg
Print Name of Authorized Person

3/7/17
Date

Board Use Only	Received: _____	Amount: <u>\$500.00</u>
-----------------------	-----------------	-------------------------

APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

List names of 4 largest partners and percentage of ownership:

Name: Jeff Griffith %: 35

Name: Brenda Brown %: 35

Name: Brandon Walend %: 20

Name: Gilbert Ursulo %: 10

Partnership Name: PBC, LLC

Mailing Address: 801 South Rancho Dr. Suite D-1A

City: Las Vegas State: NV Zip Code: 89106

Telephone: (702) 790-4404 Fax: (702) 790-4406

Contact Person: Clare-lanie Guerrero Macaraeg

List any physician shareholders and percentage of ownership.

Name: N/A %: N/A

Name: N/A %: N/A

PARTNERSHIP

Include with the application for a partnership

Designated representative form. Download the form from the website under the "New Applications" tab. The forms are available under the *documents for all types of businesses*.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an examination on law **prior** to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

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

STATEMENT OF RESPONSIBILITY - Pharmacy
For Corporations, Partnership or Sole Owners

I, BRENDA BROWN

Responsible Person of SPECIALTY CARE RX

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said company.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy or operation of a pharmacy in Nevada.

I further acknowledge and understand that upon the change of managing pharmacist in the pharmacy, the owners must assure that an accountability audit of all controlled substances shall be performed jointly by the departing managing pharmacist and the new managing pharmacist.

B.A. Brown

Original Signature, no stamps or copies

3/17/17

Date

Statement of Responsibility

Managing Pharmacist

Pharmacist Name: Clare-lanie Guerrero Macaraeg

License #: 19507

Pharmacy Name: Specialty Care RX

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1. been charged, arrested or convicted of a felony or misdemeanor in any state?	<input checked="" type="checkbox"/> No	
2. been the subject of an administrative action whether completed or pending in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If you marked YES to any of the numbered questions above, please include the following information		
Board Administrative Action:	State: _____	Date: _____ Case #: _____
And/or Criminal Action:	State: _____	Date: _____ Case #: _____
	County: _____	Court: _____