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: Cpap store USA

Physical Address: 3325 W. Desert Inn RD Suite 201

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

Mailing Address: 3325 W. Desert Inn RD Suite 201

City: Las Vegas State: NV Zip Code: 89102

Telephone: 702-908-4852 Fax: 800-439-3194

E-mail: CpapStoreUSA@gmail.com Website: www.cpapstoreusa.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 10 to 5 Sat: 10 to 5 Sun: By appointment to 3 Holidays: N/A to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Oganes Berberyan

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: Oganes Berberyan Telephone: 702-908-4852

95223

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	N/A	N/A
N/A	N/A	N/A
N/A	N/A	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: No
☐ Advanced Practitioner of Nursing	Name: No.
☐ Physician's Assistant	Name: No
☐ Physical Therapist	Name: No.
☐ Occupational Therapist	Name: No.
☐ Registered Nurse	Name: No.
☐ Respiratory Therapist	Name: No

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

Oganes Berberyan
Print Name of Authorized Person

11/1/16
Date

Board Use Only Received: _____ Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Nevada

Parent Company if any: Cpap Store USA LLC

Corporation Name: Cpap Store USA LLC

Mailing Address: 3325 W. Desert Inn RD Suite 201

City: Las Vegas State: NV Zip: 89102

Telephone: 702-908-4852 Fax: 800-439-3194

Contact Person: Oganes Berberyan

For any corporation non publicly traded, disclose the following:

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

a) Oganes Berberyan (Name) 3325 W. Desert Inn RD Suite 201 (Address)

b) N/A (Name) (Address)

c) N/A (Name) (Address)

d) N/A (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

NEVADA STATE BOARD OF PHARMACY

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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: EQUITABLE HOME MEDICAL SUPPLY INC.

Physical Address: 1404 S. DECATUR BLVD. LAS VEGAS NV 89102

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

Mailing Address: 1404 S. DECATUR BLVD.

City: LAS VEGAS State: NV Zip Code: 89102

Telephone: 702-331-3882 Fax: 702-331-6878

E-mail: POLFLORES@YAHOO.COM Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9 to 5 Sat: 9 to 3 Sun: ___ to ___ Holidays: ___ to ___

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: CORAZON ZAMORA

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: INCONTINENT SUPPLIES

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: CORAZON ZAMORA Telephone: 702-331-3882

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: N/A
☐ 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.

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

LEOPOLDO FLORES
Print Name of Authorized Person

12/12/2016
Date

Board Use Only	Received:	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: NEVADA

Parent Company if any: _____

Corporation Name: EQUITABLE HOME MEDICAL SUPPLY INC.

Mailing Address: 1404 S. DECATUR BLVD.

City: LAS VEGAS State: NV Zip: 89102

Telephone: 702-331-3882 Fax: 702-331-6878

Contact Person: LEOPOLDO FLORES

For any corporation non publicly traded, disclose the following:

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

a) LEOPOLDO FLORES 11894 PRINCIPI CT. LAS VEGAS NV 89183
Name Address

b) N/A
Name Address

c) N/A
Name Address

d) N/A
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. 1500

3) What was the price paid per share? $0.01

4) What date did the corporation actually receive the cash assets? 12/13/2016

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 12/12/2016

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

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

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

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

GENERAL INSTRUCTIONS

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

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

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

Application for DURABLE MEDICAL EQUIPMENT
Nature of MDEG

EQUITABLE HOME MEDICAL SUPPLY INC. 1404 S. DECATUR BLVD LAS VEGAS NV 89102
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:

ZAMORA — Last Name
CORAZON — First Name
PIEDAD — Middle Name

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

11894 PRINCIPI CT — Present Residence Address-Street or RFD
LAS VEGAS — City
NV 89138 — State/Zip

1404 S. DECATUR BLVD. — Present Business Address
Dates
LAS VEGAS — City
NV 89102 — State/Zip

ADMINISTRATOR — Present Position with the MDEG
Dates

Phone: 702-331-3552
Fax: 702-331-6578

Email address:

Date of Birth
TARLAC TARLAC PHILIPPINES — Place of Birth (City, County, State)

49 — Age
Social Security Number
FEMALE — Sex

BROWN — Color of Eyes
BLACK — Color of Hair
165 LBS. — Weight
5'6 — Height

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

N/A

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

If alien, registration No

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

Place N/A (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.

	PREFERRED HOMECARE	
07/2013 - 12/2016	871 GRIER DR. STE.C LAS VEGAS NV 89119	1280 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
PATIENT SERVICE SPECIALIST	ANSWERING PHONE INQUIRIES, VERIFY ELIGIBILITY PROCESS ORDERS ETC.	IRENE RODRIGUEZ
Title	Description of Duties	Name of Supervisor
	METROSTAR HOME HEALTH PRODUCTS	
08/2011 - 01/2013	5359 KINGS HWY BROOKLYN NY 11203	5040 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
BILLING REPRESENTATIVE	PROCESS PRESCRIPTION, VERIFY ELIGIBILITY BILLING MEDICARE, MEDICAID AND OTHER INSURANCE	LIOUDA MALKINA
Title	Description of Duties	Name of Supervisor
	KINGS PHARMACY & SURGICAL	
02/2011 - 08/2011	492 CLARKSON AVE. BROOKLYN NY 11203	1040 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
PHARMACY CLERK	TYPING PRESCRIPTIONS AND BILLING INSURANCES	ROY GREIF
Title	Description of Duties	Name of Supervisor
	GENERAL HOME MEDICAL SUPPLY	
03/2006 - 02/2009	717 LAKEFIELD RD STE.D WESTLAKE VILLAGE CA 91361	6450 HOURS
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
QUALIFIER / MEDICAL BILLER (N/A)	PROCESS PRESCRIPTION, VERIFY ELIGIBILITY AND BILL INSURANCES	KAMBIZ YADIDI
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
N/A		
Title	Description of Duties	Name of Supervisor
N/A		
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
N/A		
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:
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 writte

N/A

Date of photograph 12/13/16

I, CORAZON ZAMORA, 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.

Czamora
Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 12/12/2010

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 EQUIPMENT
Nature of License

EQUITABLE HOME MEDICAL SUPPLY INC. 1404 S. DECATUR BLVD. LAS VEGAS NV 89102
Name and Address of Establishment for Which License Is Requested

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

1. PERSONAL INFORMATION:

Last Name	First Name	Middle Name
FLORES	LEOPOLDO	AGUILA

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

N/A

Present Residence Address-Street or RFD	Dates	City	State/Zip
11594 PRINCIPI CT		LAS VEGAS	NV 89183
Present Business Address	**Dates**	**City**	**State/Zip**
1404 S. DECATUR BLVD		LAS VEGAS	NV 89102

Occupation: DIRECTOR OF GRANT ACCOUNTING

Phone: Residence

Business 702-892-2330

Date of Birth	Place of Birth (City, County, State)	
	CALOOCAN CITY PHILIPPINES	(~~MALE~~)
Age	**Social Security Number**	**Sex**
50		MALE

Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
BROWN	BLACK		170 LBS.	MEDIUM	5'4

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 N/A Date N/A

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

2. MARITAL INFORMATION:

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

Applicant's initial

MARITAL INFORMATION-Continued

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

Spouse's full name (Maiden) N/A S.S. No N/A

Date of Birth N/A Place of Birth N/A

Resident address N/A
Street City State Zip

Telephone: Residence N/A Business N/A

Spouse's employer N/A Occupation N/A

Address of employer N/A
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:

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 N/A

Contact person N/A

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: ERNESTO FLORES (DECEASED)			
Mother: BELEN FLORES (DECEASED)			
Father-in-Law: N/A			
Mother-in-Law: N/A			

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
ERNESTO FLORES JR Spouse		CARE HOSPITAL 1R RAWABI RIYADH KSA	REGISTERED NURSE
N/A Spouse			
N/A Spouse			
N/A Spouse			
N/A			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School	PASOLO ELEMENTARY SCHOOL	PHILIPPINES	1971 - 1976	Yes ☑ No ☐
High School	PULONG BUHANGIN HIGH SCHOOL	PHILIPPINES	1977 - 1980	Yes ☑ No ☐
College University	FAR EASTERN UNIVERSITY MANILA	PHILIPPINES	1981 - 1986	Yes ☐ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any BACHELOR OF SCIENCE MAJOR IN ACCOUNTING

College or university where obtained FAR EASTERN UNIVERSITY MANILA PHILIPPINES

Applicant's initial

5 MILITARY INFORMATION:

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

Branch N/A Date of entry-active service N/A

Date of separation N/A Type of discharge N/A

Rating at separation N/A Serial number N/A

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

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

County N/A State N/A Date registered N/A

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
01/1990 - 06/2000	165 ROSAL ST GARDEN VILLAGE	BULACAN	PHILIPPINES
07/2000 - 02/2008	2648 N GRAND OAKS DRIVE	WESTLAKE VILLAGE	CA 91361
03/2008 - 06/2009	110 ST INT NICHOLAS AVE 1L	BROOKLYN	NY 11237
06/2009 - 08/2012	7155 69TH ST APT 2	GLENDALE	NY 11385
09/2012 - 05/2013	6638 PINK PANTHER AVE	LAS VEGAS	NV 89110
06/2013 - 08/2014	7000 PARADISE RD. APT. 2023	LAS VEGAS	NV 89119
08/2014 - PRESENT	11894 PRINCIPI CT	LAS VEGAS	NV 89183

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
04/2014 - PRESENT	UNITED WAY OF SOUTHERN NEVADA 5830 W. FLAMINGO RD LAS VEGAS NV 89103	STILL EMPLOYED
Title	**Description of Duties**	**Name of Supervisor**
DIRECTOR OF GRANT ACCOUNTING	INCHARGE OF GRANTS	JOHN JOHNSON
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
02/2013 - 04/2014	NEVADA AFFORDABLE HOUSING ASSISTANCE CORP. 3011 W CHARLESTON BLVD #160 LAS VEGAS NV 89102	CAREER ADVANCEMENT
Title	**Description of Duties**	**Name of Supervisor**
ACCOUNTING SUPERVISOR	INCHARGE IN ACCOUNTING	STEPHEN LISOOK
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
09/2011 - 05/2012	NEW YORK ASIAN WOMENS CENTER 32 BROADWAY NEW YORK NEW YORK 10004	MOVED TO LAS VEGAS
Title	**Description of Duties**	**Name of Supervisor**
DIRECTOR OF FINANCE	INCHARGE OF ACCOUNTING AND FINANCE	LARRY LEE
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
06/2009 - 08/2011	CENTER AGAINST DOMESTIC VIOLENCE 25 CHAPEL ST. STE. 904 BROOKLYN NY 11201	CAREER ADVANCEMENT
Title	**Description of Duties**	**Name of Supervisor**
ASSISTANT CONTROLLER	INCHARGE IN ACCOUNTING	MICHAEL HENERY
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
10/2000 - 02/2005	GLOBAL MARKETING PARTNERS INC. 25035 DOROTHY DR. AGOURA HILLS CA 91301	MOVED TO NEW YORK
Title	**Description of Duties**	**Name of Supervisor**
CONTROLLER	INCHARGE OF ACCOUNTING AND ADMINISTRATION	PAIGE LABELLE
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
07/1997 - 10/2000	PDCP BANK MAKATI PHILIPPINES	MOVED TO USA
Title	**Description of Duties**	**Name of Supervisor**
BRANCH MANAGER	INCHARGE OF TOTAL BRANCH OPERATION	ADOLF LEDESMA
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
06/1993 - 05/1997	EQUITABLE BANKING CORPORATION MAKATI, PHILIPPINES	CAREER ADVANCEMENT
Title	**Description of Duties**	**Name of Supervisor**
ASSISTANT BRANCH MANAGER	INCHARGE OF CASH OPERATION	LYDIA PO MARIANO
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
04/1987 - 05/1993	METROPOLITAN BANK AND TRUST COMPANY MAKATI, PHILIPPINES	CAREER ADVANCEMENT
Title	**Description of Duties**	**Name of Supervisor**
CLEARING CLERK	BALANCING THE DAYS TRANSACTION	MARIO SANTOS

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 STEPHEN LISCIK	Home 477 DART BROOK PL	HENDERSON	NV	89012		4 YEARS
Employer SHOWCASE RETAIL MGT. SERVICES	Business 3785 LAS VEGAS BLVD	LAS VEGAS	NV	89109		
Name VALERIE MARTIN SMITH	Home 3951 WELSH PONY ST	LAS VEGAS	NV	89122		3 YEARS
Employer UNITED WAY OF SOUTHERN NEVADA	Business 5830 W. FLAMINGO RD	LAS VEGAS	NV	89103		
Name ~~ADORACION CAMACHO~~	Home PADRE KENNEDY HEAD START	BROOKLYN	NY			
Employer	Business					
Name ADORACION CAMACHO	Home 110 SAINT NICHOLAS AVE APT 2R	BROOKLYN	NY	11237		10 YE
Employer PADRE KENNEDY HEAD START	Business 285 BERRY ST.	BROOKLYN	NY	11249		
Name JULIE PIKAZE	Home					
Employer CENTER AGAINST DOMESTIC VIOLENCE	Business 25 CHAPEL ST STE 904	BROOKLYN	NY	11201		6 YEARS

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

N/A

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.

N/A

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 ☑

N/A

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

N/A

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

N/A

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 ☑

N/A

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 ☑

N/A

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 ☑

N/A

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 ☑

N/A

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 ☑

N/A

Date of photograph 12/13/2016

Applicant's initial

STATE OF NEVADA

ss.

COUNTY OF CLARK

I, LEOPOLDO FLORES, 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 14TH day of DECEMBER, 2016

Marilyn A Provost

Notary Public

MARILYN A. PROVOST
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 6-15-17
Certificate No: 01-69148-1

Applicant's initial

Nevada State Board of Pharmacy

431 W. PLUMB LANE • RENO, NEVADA 89509
(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444
E-mail: pharmacy@pharmacy.nv.gov • Website: bop.nv.gov

January 9, 2013

Ms. Suzy Martinez
License Specialist
Rotech Healthcare, Inc.
2600 Technology Drive, Suite 300
Orlando, Florida 32804

RE: Conversion of Vitalcare facility in Caliente, Nevada to a warehouse

Dear Ms. Martinez,

The Nevada State Board of Pharmacy is in receipt of your letter dated December 19, 2012, regarding the conversion of the above referenced MDEG provider facility to a warehouse (permit #MP00055). We will certainly deactivate that permit with the understanding that we have outlined to you before: No patient may pick up equipment there, nor may the facility house any equipment that is in need of service or in need of cleaning (i.e., no patient contact; no dispensing or servicing; no record storage and no storage of unserviced or unclean product).

Sincerely,

Larry L. Pinson, Pharm. D.
Executive Secretary

cc: Ray Seidlinger, Board Inspector
Luis Curras, Board Inspector

122510

ROTECH
HEALTHCARE INC.
We Care About Patient Care

DEC 2 4 2012

December 19, 2012

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

Re: Principle Medical Equipment, Inc.
D/B/A- Vitalcare
Permit #: MP00055
Change of Classification

To Whom It May Concern:

This is written notification that our facility Vitalcare located in Caliente, NV has converted into a warehouse. It strictly stores/houses clean durable medical equipment and oxygen for our sister facility located in Las Vegas, NV. The mailing address and ownership remain the same. The mailing address is 2600 Technology Drive, Suite 300, Orlando, FL 32804.

Please update your records accordingly. If you should require any additional information please contact me and I will get it for you immediately. As always your assistance is greatly appreciated.

Sincerely,

Suzy Martinez
License Specialist
Rotech Healthcare Inc. as parent of
Principle Medical Equipment, Inc.

122510

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: Vitalcare

Physical Address: 820 N. Spring St., Ste B, Caliente, NV 89008

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

Mailing Address: 3600 Vineland Rd, Ste 114

City: Orlando State: FL Zip Code: 32811

Telephone: 775-726-3980 Fax: 775-726-3981

E-mail: Pies.Vansoy@rolecm.com Website: NA

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:00am to 9:00am Tue: 8:00am to 9:00am Wed: 8:00am to 9:00am Thu: 8:00 to 9:00

Fri: Closed/on call to Sat: Closed/on call to Sun: Closed/on call to Holidays: Closed/on call to

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Pies Vansoy

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: Pies Vansoy Telephone: 702-449-1043

95151

12C510

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.

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

Robin L. Mencken
Print Name of Authorized Person

11/28/16
Date

Board Use Only	Received: _____	Amount: $500.00

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:

NA _____ _____ _____

_____ _____ _____

_____ _____ _____

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

OWNERSHIP IS A NON-PUBLICY TRADED CORPORATION

State of Incorporation: Florida

Parent Company if any: Rotech Healthcare Inc.

Corporation Name: Principal Medical Equipment, Inc.

Mailing Address: 3600 Vineland Rd, Ste 114

City: Orlando State: FL Zip: 32811

Telephone: 407-822-4600 Fax: 407-297-4029

Contact Person: Suzy Martinez extension 104755

For any corporation non publicly traded, disclose the following:

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

a) Please see attached
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. 1,000

3) What was the price paid per share? The equity of the company was revalued at $490,494.27 upon emergence from Bankruptcy

4) What date did the corporation actually receive the cash assets? The company emerged from bankruptcy on 9/30/13 no cash was exchanged

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

Shareholder Information

Capital Research and Management, LP 333 South Hope Street 55th Floor Los Angeles, CA 90071	46.5%
Silver Point Finance Two Greenwich Plaza 1st Floor Greenwich, CT 06830	28.6%
Vendor Capital Management 7 Times Square #3505 New York, NY 10056	20.8%
Fidelity Management & Research Company 82 Devonshire Street #FSA Boston, MA 02109	4.1%

12-2910

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 11·14·14

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

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

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

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

GENERAL INSTRUCTIONS

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

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

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

Application for Durable Medical Equipment
Nature of MDEG

Vital Care 320 N Spring ST, STE Caliente, NV 89008
Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Van Scoy — Last Name
Ries — First Name
G — Middle Name

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

432 McArthur Dr. — Present Residence Address-Street or RFD
Caliente — City
NV 89008 — State/Zip

870 N. Spring St #B — Present Business Address
Dates
Caliente — City
NV 89008 — State/Zip

Patient Servive Tech - COR — Present Position with the MDEG
Dates

Phone: 775) 726-3980
Fax: 775) 726-3981

Email address: ries.vanscoy@rotech.com

Date of Birth
Henderson NV — Place of Birth (City, County, State)

62 — Age
Social Security Number
Sex

Blue — Color of Eyes
Brown — Color of Hair
200 — Weight
6'4" — Height

Scars, tattoos or distinguishing marks and/or characteristics
birthmark on right bicep

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
12/2017	Vital Care 830 N. Spring St #B Caliente, NV 89008	16,208

Title	Description of Duties	Name of Supervisor
Patient Service Tech	set-up & delivery of oxygen equipment	Debbie Stroud

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 ination.

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TOGRAPH

IIN LAST

ERE

Date of photograph 11·19·14

I, Rios VanSoy, 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.

Rios VanSoy
Original Signature of Applicant