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
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b
☐ Partnership - Pages 1,2,3,6
☒ 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 Las Vegas

Physical Address: 4533 W. Sahara Ave. Unit 4 Las Vegas, NV 89102
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 4533 W. Sahara Ave. Unit 4

City: Las Vegas State: NV Zip Code: 89102

Telephone: 702-485-1847 Fax: 702-920-8366

E-mail: cpapstorelv@gmail.com Website: www.cpapstorevegas.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9am to 5pm Sat: 9am to 5pm Sun: 10am to 3pm Holidays: 9am to 1pm

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Tony Maltesee

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: Tony Maltesee Telephone: 702-321-7544

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APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

n/a

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

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

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

- ☐ Practitioner Name: ____________
- ☐ Advanced Practitioner of Nursing Name: ____________
- ☐ Physician's Assistant Name: ____________
- ☐ Physical Therapist Name: ____________
- ☐ Occupational Therapist Name: ____________
- ☐ Registered Nurse Name: ____________
- ☒ Respiratory Therapist Name: Tony Maltesee

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 ☒

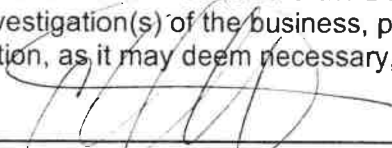
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Gevorg Muradyan
Print Name of Authorized Person

05-28-2017
Date

Board Use Only	Received: ____________	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Gevorg Muradyan

Business Name: CPAP Store Las Vegas

Current Business Address: 4533 W. Sahara Ave. Unit 4

City: Las Vegas State: NV Zip: 89102

Telephone: 702-485-1847 Fax: 702-920-8366

SOLE OWNER

Include with the application for a sole owner

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 05-25-2017

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

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

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

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

GENERAL INSTRUCTIONS

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

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

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

Application for DME

Nature of MDEG

CPAP Store Las Vegas - 4533 W. Sahara Ave Unit 4. Las Vegas, NV 89102

Name and Address of Business for Which MDEG Administrator Is Requested

....

If applicable, Name Under Which It Is Now Operated

C-

1. **PERSONAL INFORMATION:**

Maltese | Tony |
Last Name | First Name | Middle Name

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

9354 Cowboy Rain Drive . Las Vegas, NV 89178
Present Residence Address-Street or RFD | City | State/Zip

4533 W. Sahara Ave #4 Dates May 2017 Las Vegas NV, 89102
Present Business Address | City | State/Zip

Respiratory Therapist Dates May 2017 - Present.
Present Position with the MDEG

Phone: 702-321-7544 Fax:

Email address:

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

52 | | Male
Age | Social Security Number | Sex

Green | Bal | 210 | 5'10
Color of Eyes | Color of Hair | Weight | 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.)

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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.

May /2017 — CPAP Store Las Vegas — Present

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

Respiratory Therapist — Answering Patient Questions. — Gevorg.

Title | Description of Duties | Name of Supervisor

Jan - May / 2015 — St. Josephs Long Term Care Facility — 800

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

Respiratory Therapist — Patient treatment Follow-ups - Dignostic test and Reviews. — Cmari Cooper.

Title | Description of Duties | Name of Supervisor

Jan - April 2016 — Horizon Long Term Care Facility — 640 — Scott Reids

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

Respiratory Therapist — Patient Interview/treatment Follow-up - Educating Patient on treatment and equipment.

Title | Description of Duties | Name of Supervisor

OCT-NOV / 2014 — Spring Valley Hospital — 320

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

Respiratory Therapist — Conducting Dignostic tests/monitoring patient progress and treatment/patient education on equipment. — Dorian

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

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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: ______________________

Date: ______________________

Case Number: ______________________

c) Criminal Action:

State: ______________________

Date: ______________________

Case Number: ______________________

County: ______________________

Court: ______________________

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

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

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

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

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ATT

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Date of photograph..............................

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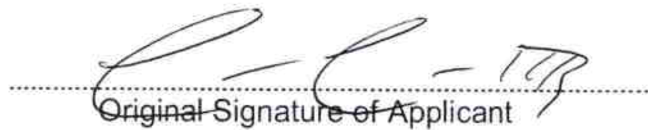
I, Tony Marcese, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation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

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



Original Signature of Applicant

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date ....

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 Gevorg Muradyan
Nature of License

Cpap Store Las Vegas - 4533 W. Sahara Ave. Unit 4 - Las Vegas, NV 89102
Name and Address of Establishment for Which License Is Requested

....
If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION: Muradyan, Gevorg

Last Name | First Name | Middle Name

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

7083 Zomera Way | Las Vegas | NV 89113
Present Residence Address-Street or RFD | City | State/Zip

4533 W. Sahara Ave. Dates 2015-Present Las Vegas, NV 89102
Present Business Address | City | State/Zip

Owner Dates 2015- Present L
Occupation

Phone:
Residence
Business 702-485-1847

Yerevan, Armenia
Date of Birth | Place of Birth (City, County, State)

29 | | Male
Age | Social Security Number | Sex

Black	Black	Fair	180	Average	5'10
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

Scars, tattoos or distinguishing marks and/or characteristics NO

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 GM

MARITAL INFORMATION-Continued

A. **Current Marriage** n/a
Date — City, County and State

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

Date of Birth ________ Place of Birth ________

Resident address ________
Street — City — State — Zip

Telephone: Residence ________ Business ________

Spouse's employer ________ Occupation ________

Address of employer ________
Street — City — State — Zip

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

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

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

Name	Street	City	State	Zip	Telephone
		n/a			

3. FAMILY INFORMATION:

A. Children and Dependents:

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

Name	Birth Date	Birth Place	Residence Address
		n/a	

B. Child Support Information:

Please mark the appropriate response:

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

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

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

Applicant's initial CM

FAMILY INFORMATION-Continued

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

Name n/a

Address

Contact person

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Muradyan, Stephan		7083 Somera Way, LV, NV 89113	selfemployeed.
Mother	Muradyan, Narine		7083 Somera Way LV, NV 89113	cashier.
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
Muradyan, Armenak		3881 Cotillion CT. LV, NV 89147	Self-Employed.
Spouse			
Spouse			
Spouse			
Spouse			

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School		Yerevan, Armenia		Yes ☑ No ☐
High School	Century High School	Los Angeles, CA		Yes ☑ No ☐
College University				Yes ☐ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any

College or university where obtained

Applicant's initial CM

5 MILITARY INFORMATION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date

Applicant's initial CM

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
Jan 2016 - Present	7083 Sonicera Way	Las Vegas	NV 89113
May 2016 - Dec 2015	3881 Cotillion Ct	Las Vegas	NV, 89147

Applicant's initial CM

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
May 2015-Present	CPAP Store Las Vegas 4533 W. Sahara Ave LV, NV 89102	
Title	**Description of Duties**	**Name of Supervisor**
Owner	Owner	n/a

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Jan-2013- Mar 2015	Las Vegas SleepLab.	Business Closed.
Title	**Description of Duties**	**Name of Supervisor**
Assistant	to the owner/Billing	Armen

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Feb 2013 - Oct 2016	Marketing Raise - Las Vegas, NV	Self-Employed.
Title	**Description of Duties**	**Name of Supervisor**
Owner.	Marketing).	n/a

Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
2009-2013	Smiles Dental - Las Vegas, NV	Another Job opening.
Title	**Description of Duties**	**Name of Supervisor**
Front Desk	Front Desk, Insurance Verification - Authorizations	

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: CM

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 John Minas	Home	Glendale, CA		8 YRS.
Employer Marketing Raise	Business	Las, Vegas, NV		
Name Nick Kazarkhanyan	Home	Las Vegas, NV		10 YRS.
Employer Marketing Raise	Business	Las Vegas, NV		
Name Aylin Manasyan	Home	Glendale, CA		6 YRS.
Employer n/a	Business	n/a		
Name Elizabeth Minasyan	Home	Los Angeles, CA		12 YRS
Employer n/a	Business	n/a		
Name Sam Bedros	Home	Las Vegas, NV		12 YRS
Employer n/a	Business	n/a		

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

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

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

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

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

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

Applicant's initial GM

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

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

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

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

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

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

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

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

Date of photograph 05-28-2017

Applicant's initial GM

STATE OF Nevada ss.

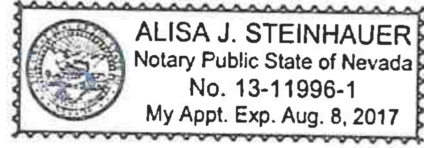
COUNTY OF Clark

I, Gevorg Muradyan, 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 6th day of June, 2016



ALISA J. STEINHAUER
Notary Public State of Nevada
No. 13-11996-1
My Appt. Exp. Aug. 8, 2017

Notary Public

(seal)

Applicant's initial GM

NEVADA STATE BOARD OF PHARMACY

OFFICE OF THE GENERAL COUNSEL

WRITER'S DIRECT DIAL: (775) 850-1440 • E-MAIL: PEDWARDS@PHARMACY.NV.GOV • FAX: (775) 850-1444

May 17, 2017

BY CERTIFIED U.S. MAIL AND ELECTRONIC MAIL

CPAP Store Las Vegas
4533 W. Sahara Ave., Suite #4 9171 9690 0935 0141 9726 52
Las Vegas, Nevada 89102

Attention: Selena Huerta
Stella Margaryan
Gevorg Murdyan
George Muradyan

RE: CEASE AND DESIST UNLICENSED SALES OF PRESCRIPTION MDEG PRODUCTS

Dear Ms. Margaryan:

The Nevada State Board of Pharmacy (Board) recieved complaints and has information indicating that your store, CPAP Store Las Vegas (aka C PAP Store Las Vegas LLC and/or My C PAP Store LLC) has for approximately two years operated as a Nevada Medical Devices, Equipment and Gases (MDEG) retailer and sold prescription only (Rx Only) MDEG products in Nevada without a Nevada MDEG license, The Board's records show that your company holds no license in Nevada under any of the names listed above.

I am writing to direct you, both personally and as owners, managers and operaters of CPAP Store Las Vegas, along with its affilicates, to CEASE and DESIST all sales of products that require a prescription until after you have applied for and been granted a MDEG license by the Board. The link to the application for a Nevada out-of-state pharmacy license is at: *http://bop.nv.gov/uploadedFiles/bopnvgov/content/Services/newapps/2012_MDEG_NV.pdf*

Secondly, this letter shall serve as a CITATION pursuant to NRS 639.2895(2), citing CPAP Store Las Vegas for unlicensed practice. For the violations stated above, the Board is assessing your company an administrative fine of five thousand dollars ($5,000.00), or $100.00 per day for each day that the store operated without a license, capped at the $5,000.00 maximum allowed by law. *See* NAC 639.955(f).

CPAP Store Las Vegas shall pay this administrative fine within 30 days of receipt of this citation, or otherwise contact the Board Office in Reno, Nevada to request an alternative payment plan. Payment must be by *cashier's check*, *certified check* or *money order* made payable to the Nevada State Board of Pharmacy. Send all payments to the Board's Reno office, located at 431 W. Plumb Lane, Reno, NV 89509.

CPAP Store Las Vegas has the right to appeal this citation if it chooses. *See* NRS 639.2895(2). To do so, it must submit a written request for a hearing to the Board's Executive Secretary, Dr. Pinson, at the Board's Reno Office no later than 30 days after receipt of this letter. If CPAP Store Las Vegas submits a request for hearing, I strongly advise that it submit with it any evidence it wishes the Board to consider. At a hearing, CPAP Store Las Vegas would bear the burden to show that this citation was issued in error.

In the event that CPAP Store Las Vegas wishes to obtain a Nevada license or registration in the future, it should be aware that the Board could also request that it attend a hearing to discuss this matter as part of its consideration of its application. The citation and an application can be addressed at the same hearing at CPAP Store Las Vegas's request.

Feel free to contact me if you have questions.

Best regards,

S. Paul Edwards
General Counsel
Nevada State Board of Pharmacy

Cc: Robert Hernquist, Esq., Howard & Howard Attorneys P.L.L.C.; Larry Pinson, Pharm.D. Executive Secretary, Nevada State Board of Pharmacy; David Wuest, R.Ph., Deputy Executive Director, Nevada State Board of Pharmacy

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
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b
☐ Partnership - Pages 1,2,3,6
☒ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Las Vegas Medical Store

Physical Address: 4527 W. Sahara Ave. Las Vegas, NV 89102
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 4527 W. Sahara Ave.

City: Las Vegas State: NV Zip Code: 89102

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

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

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 10am to 5pm Sat: 10am to 5pm Sun: 10am to 2pm Holidays: to -Closed.

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Ana P. Gonzalez

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: Ana P. Gonzalez Telephone: 702-813-7173

97185

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

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

n/a

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

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

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

- ☐ Practitioner — Name:
- ☐ Advanced Practitioner of Nursing — Name:
- ☐ Physician's Assistant — Name:
- ☐ Physical Therapist — Name:
- ☐ Occupational Therapist — Name:
- ☐ Registered Nurse — Name:
- ☒ Respiratory Therapist — Name: Ana P. Gonzalez

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

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

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

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

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

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

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

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

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

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

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

Armenak Muradyan
Print Name of Authorized Person

06.07.2017
Date

Board Use Only	Received: ____________	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: ARmenak Mukadyan

Business Name: Las Vegas Medical Store

Current Business Address: 4527 W. Sahara Ave.

City: Las Vegas State: NV Zip: 89102

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

SOLE OWNER

Include with the application for a sole owner

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 06.07.2017

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

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

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

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

GENERAL INSTRUCTIONS

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

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

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

Application for DME

Nature of MDEG

Las Vegas Medical Store - 4527 W. Sahara Ave. Las Vegas, NV 89102

Name and Address of Business for Which MDEG Administrator Is Requested

If applicable, Name Under Which It Is Now Operated

AS

1. PERSONAL INFORMATION:

Gonzalez — Last Name
Ana — First Name
P — Middle Name

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

2437 Twin Flower Cir L.V. NV 89134
Present Residence Address-Street or RFD — City — State/Zip

4527 W. Sahara Ave. Las Vegas, NV 89102 Dates March 2017, Present
Present Business Address — City — State/Zip

Respiratory Therapist Dates March 2017
Present Position with the MDEG

Phone: (702) 813-7173 Fax: ______

Email address: APGLB1@icloud.com

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

48 — Age
Social Security Number ______
F — Sex

Brown — Color of Eyes
Brown — Color of Hair
158 — Weight
5'6" — Height

Scars, tattoos or distinguishing marks and/or characteristics Ø

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.)

AG

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
March 2017-Present	Las Vegas Medical Store / Las Vegas NV	240 +

Title	Description of Duties	Name of Supervisor
Respiratory Therapist	- Business not open yet.	Armenak

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
2013-Present	UMC Hospital / Las Vegas, NV	Per Diem / 650 +

Title	Description of Duties	Name of Supervisor
RRT	monitor and document Patient Therapy.	

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
2010-2013	St. Teresa Specialty Hospital New Orleans, Louisiana	960.

Title	Description of Duties	Name of Supervisor
RRT	setup & document patient Therapy; monitor & set up patient machinery	

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:
b)

State: ______________________

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 ☐

I[illegible]s 4, 5 or 6 please provide a written letter of explanation.

ATTACH PHOTOGRAPH

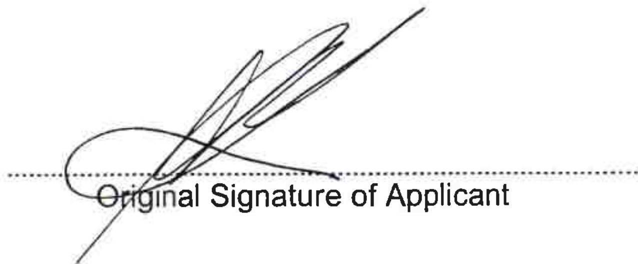
TAKEN WITHIN LAST

30 DAYS HERE

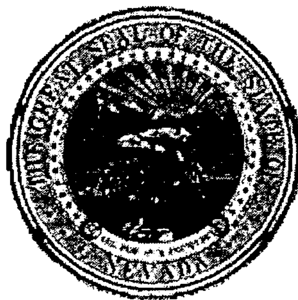
Date of photograph 06 07 2017

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

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



Original Signature of Applicant



NEVADA STATE BOARD OF MEDICAL EXAMINERS

Search

Licensee Details

Person Information	
Name:	Ana P. GONZALEZ
Address:	2437 TWIN FLOWER CIRCLE Las Vegas NV 89134
Phone:	7028137173

License Information			
License Type:	Practitioner of Respiratory Care		
License Number:	RC2228	Status:	Active
Issue Date:	2/22/2013	Expiration Date:	6/30/2019

Scope of Practice

Scope of Practice: Respiratory Care

Education & Training

School:	Holy Angels Academy / New Orleans , LA
Degree\Certificate:	High School Diploma
Date Enrolled:	
Date Graduated:	5/16/1984
Scope of Practice:	

School:	Louisiana State University / New Orleans , LA
Degree\Certificate:	Practitioner of Respiratory Care Degree
Date Enrolled:	5/1/1989
Date Graduated:	8/17/1991
Scope of Practice:	Respiratory Therapy

School:	Tulane School of Public Health / New Orleans , LA
Degree\Certificate:	Masters
Date Enrolled:	

Date Graduated: 12/16/1994
Scope of Practice: Public Health

CURRENT EMPLOYMENT STATUS/CONDITIONS/RESTRICTIONS ON LICENSE AND MALPRACTICE INFORMATION

NONE

Board Actions

NONE

Please note that the settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee even though there is a closed malpractice claim on file. A payment in the settlement of medical malpractice does not create a presumption that medical malpractice occurred. Sometimes insurance companies settle a case without the knowledge and/or agreement of the physician. This database represents information from insurers to date. Please note: All insurers may not have submitted claim information to the Board.

Close Window

PERSONAL HISTORY RECORD for Pharmacy, MDEG & Wholesaler

Date 5-25-2017

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 herein 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 Armenak Muradyan
Nature of License

4527 W. Sahara Ave. Las Vegas, NV 89102 - Las Vegas Medical Store
Name and Address of Establishment for Which License Is Requested

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Muradyan, Armenak
Last Name First Name Middle Name

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

3881 Cotillion CT. Las Vegas NV, 89147
Present Residence Address-Street or RFD City State/Zip

4527 W. Sahara Ave. Dates 03-2017-Present Las Vegas, NV 89102
Present Business Address City State/Zip

Owner Dates 03 2017 - Present
Occupation

Phone:
Residence

Business 702-808-1365

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

30 Male
Age Social Security Number Sex

Brown	Brown	Fair	210	Medium	5'11
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height

Scars, tattoos or distinguishing marks and/or characteristics N/A - None.

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

If naturalized, certificate No Date

Place (If naturalized, document must be verified.)

2. MARITAL INFORMATION:

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

Applicant's initial AM

MARITAL INFORMATION-Continued

A. **Current Marriage** 06-07-2015 (Date) Las Vegas, NV - Clark County (City, County and State)

Spouse's full name (Maiden) Ayvazyan, Lilit S.S. No. 7

Date of Birth Place of Birth Yerevan, Armenia

Resident address 3881 Cotillion CT (Street) Las Vegas (City) NV (State) 89147 (Zip)

Telephone: Residence 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:

Name	Birth Date	Birth Place	Residence Address

B. Child Support Information:

Please mark the appropriate response:

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

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

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

Applicant's initial AM

FAMILY INFORMATION-Continued

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

Name n/a

Address

Contact person

C. Parents:

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

	Name (Maiden)	Birth Date	Address	Occupation
Father	Muradyan, Stepan		7083 Sonnera Way Las Vegas, NV 89113	Self-Employeed
Mother	Muradyan, Narine		7083 Sonnera Way Las Vegas, NV 89113	Cashier.
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
	Muradyan Gevorg		7083 Sonnera Way Las Vegas, NV 89113	Self-Employed.
Spouse	n/a			
Spouse				
Spouse				
Spouse				

4. EDUCATION:

	Name of School	Location	Dates Attended	Graduate
Grammar School		Yerevan, Armenia		Yes ☒ No ☐
High School	Glendale High School	Glendale, CA		Yes ☒ No ☐
College University				Yes ☐ No ☐
Other				Yes ☐ No ☐

Type of degree obtained, if any

College or university where obtained

Applicant's initial AM

5 MILITARY INFORMATION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Name	Relationship	Charge	Location	Date

Applicant's initial AW

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

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

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

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

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

7. RESIDENCES:

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

Month and Year (From-To)	Street and Number	City	State or County
2004 -2009	524 E Acacia Ave.	Glendale	CA 91205.
2009- 2014	7083 Sonneka Way	Las Vegas,	NV 89113
2014 - Present	3881 Cotillion CT.	Las Vegas,	NV 89147

Applicant's initial ......AM......

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
May 2017-Present	Las Vegas Medical Store 4527 W. Sahara Ave. Las Vegas, NV 89102	
Title	**Description of Duties**	**Name of Supervisor**
Owner	Owner	n/a
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
May 2015-Dec 2016	CPAP Store Las Vegas 4533 W. Sahara Ave. Las Vegas, NV 89102	Resigned position
Title	**Description of Duties**	**Name of Supervisor**
Assistant	Assistant to Owner.	Gevorg
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
2009-2016	Pastry Palace	Stephan
Title	**Description of Duties**	**Name of Supervisor**
marketing	marketing	owner.
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**
Month and Year	**Name/Mailing Address of Employer/Business**	**Reason for Leaving**
Title	**Description of Duties**	**Name of Supervisor**

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

Applicant's initial AW

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 Rafo Kottukjian	Home	Las Vegas, NV				12
Employer Self-Employed	Business	Body Shop.				
Name Arthur Stephans	Home	Las Vegas, NV				10
Employer Self Employed	Business	Body Shop.				
Name Rafael Shanazit	Home	Las Vegas NV				20
Employer Self Employed	Business	UBER - Transportation				
Name Hovaness Balayan	Home	Las Vegas, NV				12
Employer Self Employed	Business	Transportation.				
Name Robert Kottukjian	Home	Las Vegas, NV				8
Employer Self Employment	Business	Body Shop.				

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

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

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

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

Yes ☐ No ☒

If yes, state type, where and years held

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

Applicant's initial Am

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

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

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

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

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

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

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

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

Date of photograph 05-28-2017

Applicant's initial AM

STATE OF Nevada
ss.
COUNTY OF Clark

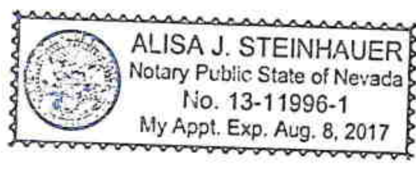
I, Armenak Muradyan, being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that 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 12th day of June, 2017 by Armenak Muradyan

Alisa J. Steinhauer
Notary Public



(seal)

Applicant's initial AM

MDEG PROVIDER

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: RELIANT MEDICAL GROUP, LLC

Physical Address: 3111 S. VALLEY VIEW BLVD #A-220 LAS VEGAS NV 89102
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 9831 VENUS LAKE COURT ~~LAS~~

City: Las Vegas State: NV Zip Code: 89178

Telephone: 702-719-9042 Fax: 800-340-2955

E-mail: esmith@reliantmedicalsupply.com Website: www.reliantmedicalsupply.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5pm Tue: 9am to 5pm Wed: 9am to 5pm Thu: 9am to 5pm
Fri: 9am to 5pm Sat: appt. only to ____ Sun: close to ____ Holidays: close to ____ XMAS, Easter

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Elaine Cardenas-Smith

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

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

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

97278

APPLICATION FOR NEVADA MDEG LICENSE

This page must be submitted for all types of ownership. None

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

__________ __________ __________

__________ __________ __________

__________ __________ __________

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: N/A
☐ 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

<u>This page must be submitted for all types of ownership.</u>

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 ☒

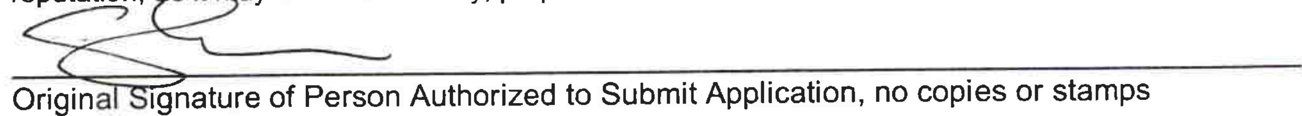
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Elaine Cardenas-Smith

Print Name of Authorized Person

6/12/17

Date

Board Use Only	Received: ____________	Amount: $500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Elaine Cardenas-Smith

Business Name: RELIANT MEDICAL GROUP, LLC

Current Business Address: 3111 S. VALLEY VIEW BLVD #A-220

City: Las Vegas State: NV Zip: 89102

Telephone: 702-719-9042 Fax: 800-340-2955

SOLE OWNER

Include with the application for a sole owner

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 6/12/17

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

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

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

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

GENERAL INSTRUCTIONS

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

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

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

Application for Durable medical equipment provider

Nature of MDEG

3111 S. Valley View Blvd. A-220 Las Vegas NV 89102

Name and Address of Business for Which MDEG Administrator Is Requested

Reliant medical Group LLC. dba Reliant medical supply

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Cardenas-Smith — Last Name | Elaine — First Name | Jane — Middle Name

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

VENUS LAKE COURT LAS VEGAS NV ~~89102~~ 89178
Present Residence Address-Street or RFD | City | State/Zip

3111 S Valley View Blvd Las Vegas NV 89102 Dates 6/30/16 – present
Present Business Address | City | State/Zip

President Dates 6/30/16 - present
Present Position with the MDEG

Phone: 702-719-9042 Fax: 800-340-2955

Email address: esmith@reliantmedicalsupply.com

Date of Birth: ____ | Place of Birth (City, County, State): Manila Philippines

Age: 35 | Social Security Number: ____ | Sex: Female

Color of Eyes: Brown | Color of Hair: Brown | Weight: 140 | Height: 5 1

Scars, tattoos or distinguishing marks and/or characteristics
"carpe diem" left wrist "†" (cross) on right wrist

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
5/15-6/16	REHAB MEDICAL - Las Vegas office shut down HQ-6365 Castleplace Dr. Indianapolis, IN 46250	1800+

Title	Description of Duties	Name of Supervisor
Sales - Acct Mgr.	worked marketing and sales to patients Dr's, PT's, Hospitals, Clinics	John Skaggs, Keith, Vicki

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
8/13 – present	LabTest Certification Inc. 3255 Pepper Lane Las Vegas NV 89120	6500+

Title	Description of Duties	Name of Supervisor
Sales - Acct Mgr.	Sales on testing and certification on electrical safety manufacturing medical equipment knowledge of medical products before it reaches the clinics and dr's. offices	Robert Grady

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
6/30/16 - Present	Reliant medical supply	700+

Title	Description of Duties	Name of Supervisor
President	marketing / product research / and sales of medical supplies and equipment	Self -

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

Title	Description of Duties	Name of Supervisor

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

Title	Description of Duties	Name of Supervisor

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

Title	Description of Duties	Name of Supervisor

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

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

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

a) Board Administrative Action: State: ______________________
b)
Date: ______________________

Case Number: ______________________

c) Criminal Action: State: ______________________

Date: ______________________

Case Number: ______________________

County: ______________________

Court: ______________________

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

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

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

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

....

....

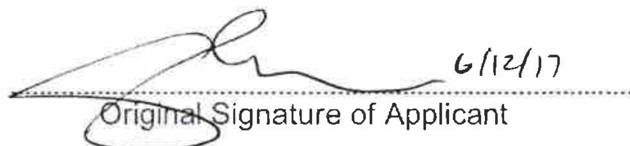
....

....

.... Date c ....

I, Elaine Cardenas-Smith, 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.


6/12/17

Original Signature of Applicant

MDEG WHOLESALER

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
☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b
☐ Partnership - Pages 1,2,3,6
☒ 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: RELIANT MEDICAL GROUP, LLC

Physical Address: 3111 S. Valley View Blvd #A-220 Las Vegas NV 89102
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 9831 Venus Lake Court

City: Las Vegas State: NV Zip Code: 89178

Telephone: 702-719-9042 Fax: 800-340-2953

E-mail: esmith@reliantmedicalsupply.com Website: www.reliantmedicalsupply.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

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

Fri: 9am to 5pm Sat: appt only to Sun: close to Holidays: close to Xmas, Easter

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: Elaine Cardenas-Smith

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

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

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

97252

APPLICATION FOR NEVADA MDEG LICENSE

<u>This page must be submitted for all types of ownership.</u> none

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

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

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: __________

<u>Practicing</u> 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 ☒

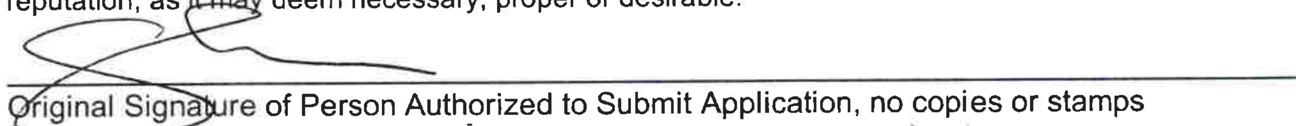
4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☒

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

Elaine Cardenas-Smith — 5/10/17

Print Name of Authorized Person — Date

Board Use Only	Received: ______	Amount: 500.00

APPLICATION FOR NEVADA MDEG LICENSE

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

Owner's Name: Elaine Cardenas-Smith

Business Name: Reliant Medical Group, LLC

Current Business Address: 3111 S Valley View Blvd. A-220 Las Vegas NV 89102

City: Las Vegas State: NV Zip: 89102

Telephone: 702-719-9042 Fax: 800-340-2955

SOLE OWNER

Include with the application for a sole owner

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

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

Date 6/12/17

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

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

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

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

GENERAL INSTRUCTIONS

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

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

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

Application for medical supplies and equipment - Distributor / wholesaler

Nature of MDEG

3111 S. Valley View Blvd. # A-220 Las Vegas NV 89102

Name and Address of Business for Which MDEG Administrator Is Requested

RELIANT MEDICAL GROUP LLC dba Reliant medical supply

If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Cardenas-Smith	Elaine	Jane
Last Name	First Name	Middle Name

Elaine Jane Cardenas

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

VENUS LAKE COURT LAS VEGAS, NV 89178

Present Residence Address-Street or RFD City State/Zip

311 S. Valley View Blvd #A-220 LAS VEGAS NV 89102 Dates 6/30/16 – Present

Present Business Address City State/Zip

President Dates 6/30/16 – Present

Present Position with the MDEG

Phone: 702-719-9042 Fax: 800-340-2955

Email address: esmith@reliantmedicalsupply.com

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

35		Female
Age	Social Security Number	Sex

Brown	Brown	140	EK 6/12/17 5'1
Color of Eyes	Color of Hair	Weight	Height

Scars, tattoos or distinguishing marks and/or characteristics

"carpe diem" left wrist – cross "✝" right wrist

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. Las Vegas office shut down

Rehab medical -

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
5/15 - 6/16	Rehab medical - HQ - 6365 Castleplace Dr. Indianapolis IN, 46250	1800 +

Title	Description of Duties	Name of Supervisor
Sales - Acct Mgr	Worked in Sales of DME supplies at Hospitals, PT, and Dr. offices	John Skaggs, Keith, Vicki

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
8/13 - Present	LabTest Certification Inc. 3255 Pepper Lane Las Vegas NV 89120	6500+ hrs.

Title	Description of Duties	Name of Supervisor
Sales Acct mgr.	Dealt w/ electrical safety testing and certification of medical equipment manufactured	Robert Gradney

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
6/30/16 - Present	Reliant medical supply 3111 S Valley View Blvd A-220 Las Vegas NV 89102	700 +

Title	Description of Duties	Name of Supervisor
President	marketing/ product research/ and sales of medical supplies & equipment	Self -

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:
b)

State: ______________________

Date: ______________________

Case Number: ______________________

c) Criminal Action:

State: ______________________

Date: ______________________

Case Number: ______________________

County: ______________________

Court: ______________________

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

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

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

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

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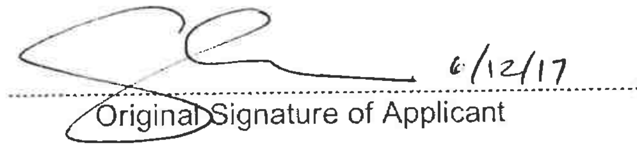
.... Date ....

I, Elaine Cardenas-Smith, 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.



6/12/17

Original Signature of Applicant