NEVADA STATE BOARD OF PHARMACY

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

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

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

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

Application must be printed legibly or typed

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

New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change (Please provide current license number if making changes: MP or MW)
☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6 ☐ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7 Please check box for type of ownership and complete correct part of the application.
GENERAL INFORMATION to be completed by all types of ownership
MDEG Name: CPAP CTORE LAS VEGAS
Physical Address: 4535 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. Gahara Ave. Unit 4
City: Las Vegas State: NV Zip Code: 89102
Telephone: 702-485-1847 Fax: 702-920-8366
E-mail: CPAPStore IV @ gmail· Com Website: WWW-CPAPSTOVEVEGAS.com
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 9am to 5pm Tue: 9am to 5pm Wed: 9nm to 5pm Thu: 9am to 5pm
Fri: am to 5pm Sat: 9am to 5pm Sun: 10am to 3pm Holidays: 9am to 1pm
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: TONY MONTESEE
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
☐ Medical Gases** ☐ Assistive Equipment
 ✓ Respiratory Equipment** ☐ Life-sustaining equipment** ☐ Orthotics and Prosethics
☐ Diabetic Supplies 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: Ith Montes Page 1

<u>This</u>	page must be submitted for all types of c	ownership.		
List a	all Medicare and Medicaid provider numb	pers registered to the business or it	s owner:	
-	na	· · · · · · · · · · · · · · · · · · ·		
1)	Do any shareholders hold an interest of any type of business or facility which a or another political jurisdiction?		Yes □	No ⊠
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?		Yes ⊠	No □
3)	Are any of the owners health profession	nals? If yes, please check the box	and list	name.
	 □ Practitioner □ Advanced Practitioner of Nursing □ Physician's Assistant □ Physical Therapist □ Occupational Therapist □ Registered Nurse ☒ Respiratory Therapist 	Name:Name:Name:Name:Name:Name:Name:Name:Name:Name:Name:Name:Name:Name:Name:		

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

This page must be submitted for all types of ownership.

Within	n the last five (5) y	rears:					
1)	any interest, ever	ion, any owner, sharel r been charged, or cor cluding by way of a gu	rvicted of a feld	ony or gros	SS	Yes □	No 🖄
2)		ion, any owner(s), sha r been denied a licens			with	Yes □	No ⊠
3)	interest, ever bee	ion, any owner(s), sha en the subject of an ad armaceutical industry?	ministrative ac	partner(s) tion or pro	with any ceeding	Yes □	No ⊠
4)	interest, ever bee	ion, any owner(s), sha en found guilty, pled g y offense federal or st	uilty or entered	l a plea of	with any nolo	Yes □	No ⊠
5)	interest, ever sur	ion, any owner(s), sha rrendered a license, po erwise (other than upo	ermit or certific	ate of regi	stration	Yes □	No ⊠
attach	answer to question ed. Copies of any er disposition may	ns 1 through 5 is "yes and documents that ident be required.	", a signed stat ify the circums	ement of e tance or c	explanation ontain an o	must be rder, agr	eement
I unde	rstand that any infra	swers given in this applaction of the laws of the ror wholesaler may be	State of Nevada	regulating	the operation	on of an	d correct
penalty hereby any inv	y of perjury, that the authorize the Neva estigation(s) of the	answers and statements information furnished of ada State Board of Phar business, professional, n recessary, proper or d	on this applicatio macy, its agents social and mora	n are true, s, servants	accurate an	d correct.	. T
Origin	al Signature of Pe	rson Authorized to Su	bmit Applicatio	n, no copi	es or stamp	os	
Gev Print N	Variation of Authorized	d Person)5-28- <u>2</u> Date	017-		
Roard	Hee Only	Peceived:		Amount	\$500.00	,	,

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

Owner's Name: Gevorg Muradyan

Business Name: CPAP CTDRL LAS VegaS

Current Business Address: 4533 W. Sahara Ave Unit 4

City: Las Vegas State: NV Zip: 89102

Telephone: 702-485-1847 Fax: 702-920-83606

SOLE OWNER

Include with the application for a sole owner

<u>Complete personal history record</u> 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

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	
CPAP STORO !	Nature of MDEG OS VOYOS-4533 N. SONOKOI FNE UNITY. LOSVANSINV E9102	•
Name	and Address of Business for Which MDEG Administrator Is Requested	•
	If applicable, Name Under Which It Is Now Operated	

1. PERSONAL INFORMATION: Maltese Last Name Middle Name Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise) 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 Present Position with the MDEG Phone: 702 - 321 - 7544 Fax: _____ Email address: Place of Birth (City, County, State) Date of Birth Social Security Number arren 210 510 Color of Eyes Weight Height Scars, tattoos or distinguishing marks and/or characteristics NA 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.

nay/2017	CPAP Stope Las Vegas	Present
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
20spipatory The	erapist Answering Patient Questions	. Crevorg.
Title	Description of Duties	Name of Supervisor
Jan - May /2015	Ct. 102-plas Lange toping Ochen Flacial	the an
Month and Year	St Josephs Long Trem Care Fucil Name/ Address of Employer/Business	No of Employed Hours
Respiratory TI	Description of Duties-Dignostic test of Reviews.	ups - CMARI Cooper and Name of Supervisor
Jan - April 2016 Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Respipatory Th	Description of Duties Educating Patier On transport	Name of Supervisor
XT-NOV/2014	Spring Valley Hospital	320
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
RESPIRATORY These	agaist - Conducting Dignostictests/monit	veing - Presen
Title	Description of Buties patient progress and treatment/patien auccition on eq	Name of Supervisor uipment.
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

or a physical condition that would impair my license, including alcohol or substance abu	y ability to perform any of the essen	s for a mental llines Itial functions of my		
1. I have □ I have not反 been charg	ged, arrested or convicted of a felon	y or misdemeanor.		
 I have □ I have not □ been the sepending. 	ubject of an administrative action wh	nether completed o		
 I have □ I have not □ had a licen disciplined, including any action aga 	se suspended, revoked, surrendere inst a professional license that was	ed or otherwise not made public.		
If you checked "I have" to questions 1, 2 an provide a written explanation and/or docum	nd/or 3, please include the following nents.	information and		
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 operation of the MDEG?	aware of the daily	Yes ⊠ No □		
5 .Will you be employed fulltime with the	ne MDEG?	Yes ⊠ No □		
6 .Will you be present at the site of the during its normal operating hours?	MDEG	Yes 阪 No □		
If you answer No to questions 4, 5 or 6 plea	ase provide a written le	- A		
	ATT T/			
	LISTA OF PROTOGRAPH			



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

Fri Data	
∵ Date	
(o	****************************

Page 1

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	***************************************	GENORA	Muradya	<u> </u>	
CPAP Sture L	as Voljas - 453. Name	B W Sahara and Address of Establish	of License AVQ . UNITY ment for Which Licens	Las Vogas / N e is Requested	V 99102
	***************************************	If applicable, Name Und	er Which It Is Now Op	perated	
1. PERSONAL	INFORMATION:	Murachan	, Gevorg	N.	
Last Name		First Name		Middle Name	
Alias(es, Nicknames,	Maiden Name, Other Na	me Changes, Legal or Oth	nerwise)		
7003 SON	nera Way	LCI	s regas	NV	89113
	ddress-Street or RFD	(City	State	/Zip
4533 W. Sal	naka five.	Dates 2015-PR	esent Las	5 Vegas IN	W 89102
Present Business Ad		(City	State	/Zip
owner		Dates 2015- 1	PRESENT	L	
Occupation				Phone: Residence	
		Yerevan, A	pna omia	Business 70	2-485-1647
Date of Birth		Place of Birth (City, C	Committee of the Commit		
29					Mare
Age	Social	Security Number			Sex
Black	Black	Tair	180	Average	5'10
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Scars, tattoos or	distinguishing marks	and/or characteristic	cs NO		***************************************
Are you a citizen	of the United States	? Yes 🛣 No 🗆 🗈	f alien, registration	n No	
If naturalized, cer	tificate No		Date	*******************************	***************************************
Place		***************************************	(If natural	ized, document mu	ust be verified.)
2. MARITAL IN	IFORMATION:				
Single 🎾 Ma	rried 🗆 Separate	ed Divorced	□ Widowed	☐ Engaged [
				Applicant's initia	1 Cm

MARITAL INFORMATION-Continued

Α.	Current Marri	age	nla •					
	Spouse's full n	Dat ame (Maiden)	e	0082000300000	City, S.S	County ar . No	d State	

	Resident addre	essstreet				**********	··· <u>·</u>	******
		lesidence						
	Spouse's empl	loyer		Occupation				••••••
	Address of em	ployer Street		City	S	State	Zip	
B. Pi		jes: If ever legally se						
Name	of Spouse	Date of Order or Decree	Date of Place of Marriage		ure of	City	nty and State	
			nla					
		current address and						
	Name	Street	City NA	State)	Zip	Telephone	
			IIIci					
						-		
3. FA	AMILY INFORMA							
	List all ch	ildren, including step- Birth Date				e followi		-
	, tonic	y	10		71001	sonce / lac		
			.,					
В.	Child Support	t Information: mark the appropriat	e response:					
	⊠ . Iar	n not subject to a coເ	urt order for the supp	oort of child.				
	pla	n subject to a court on approved by the disthet amount owed purs	strict attorney or other	er public agen				
	the	n subject to a court o	oved by the district a	attorney or oth				
	tne	repayment of the am	iount owed pursuan	t to the order.	Applica	nt's initi	al CM	

Muradyan, Stephan 7063 Somuera Way, LV, NV 89113 Autadyan, Northe Formation Stephan Autadyan, Northe Formation Stephan Fo	LWMIL	District attorney or public ag		r enforcing the child s	upport order:		
Address Contact person C. Parents: List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, just again quardian. If refired or deceased, list last address and occupation. Name (Maldern) Bern Date Address Occupation Father Address Occupation Father Address Occupation Set Cemptoyeed Address Occupation Father Address Occupation Address Occupation Address Occupation Address Occupation Occupation Address Occupation		Name	V/C)				
Contact person. C. Parents: List names, residence addresses, dates of birth and most recent occupations of parents, step-parents. parents: In-law or legal quardian. If retired or deceased, list last address and occupation. Name (Madren) Birth Date Address Occupation Self Compiloyee of Managery (No. No. No. No. No. No. No. No. No. No.		Address					
List names, residence addresses, dates of birth and most recent occupations of parents, step-parents, in-law or legal guardian. If retired or deceased, list last address and occupation. Member Market Miladen		Contact person				***************************************	
In law or legal guardian. If retired or deceased, list last address and occupation. Name (Maiden) Birth Date Address Oscupation Sericomployeed Address Oscupation Sericomployeed Address Oscupation Oscupa		List names, residence addre	sses, dates of birth	and most recent occu	upations of parent	s, step-parents,	
Address Occupation Father Self-Employeed Address Occupation Self-Employeed Address Occupation Self-Employeed Address Occupation 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 (Maister) Birth Date Address Occupation Addr	parents	S-					
MUMAYON, Stephan AUMAYON, NORING Tather-in-Law Nother-in-Law NORING 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 (Matter) Birth Date Address Occupation MUMOCYON, ARMUNAR 3881 COTILION CT. IV, NV 89147 Sepouse 4. EDUCATION: Spouse 4. EDUCATION: Spouse Applicant's initial Applicant's initial Applicant's initial Applicant's initial Applicant's initial Applicant's initial		Name (Maiden)			occupation.	Occupation	
Mother August Stephan August N. N. Ball 2 Cashier August N. N. Ball 2 Cashier August N. N. Ball 3 Cashier August N. N. Ball 4 Cashier August N. Brith Date August N. N. Ball 4 Cashier August N. Brith Date August N. Spouse Spous	Father					SOLOMOIDIO	. ای
AUCONOMINATION: Spouse A EDUCATION: Name of School Very Chool Los Angues, CA Los Angues, CA Applicant's initial Applicant's initial Mother-in-Law Nother-in-Law	MUIC Mother	adyan, Stephan	-	- 7083 m	onieka Wa	ub, LV, NV 89	113
Mother-in-Law 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 (Mailen) Birth Date Address Occupation		1 - 1 - 1 × 1 × 1 × 1			ncera War		
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 MURCOYCN), ARMUNGK 3981 COTINION CT, IV, NV 89147 Spouse Spouse 4. EDUCATION: Name of School Location Dates Attended Graduate Frammar Chool Location Here Company High Company H	Father-in	-Law '	nla			1	
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 ALVACYCN, ALYMAR 3981 COTILION CT. IV, NV 89147 Spouse Spouse 4. EDUCATION: Signature Name of School Location Dates Attended Graduate Frammar Name of School Location Helph Company High School Los Angues, CA Yes No College Indeptional School Where No College Yes No College Yes No College or university where obtained Applicant's initial CMM Applicant's initial CMM	Mother-in	n-Law	1110		· · · · · · · · · · · · · · · · · · ·		
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 ALVACYCN, ALYMAR 3981 COTILION CT. IV, NV 89147 Spouse Spouse 4. EDUCATION: Signature Name of School Location Dates Attended Graduate Frammar Name of School Location Helph Company High School Los Angues, CA Yes No College Indeptional School Where No College Yes No College Yes No College or university where obtained Applicant's initial CMM Applicant's initial CMM			nla				
Spouse Name of School Location Dates Attended Graduate Graduate Strammar Chock Spouse Spouse Name of School Location Dates Attended Graduate Yes S No C Spouse Spouse Name of School Location Dates Attended Graduate Yes S No C Spouse No C Yes C No C Spouse Applicant's initial Applicant's initial Applicant's initial	D.	List names, residence addres their respective spouses.			pations of brother		
Spouse Serif - Employ Spouse 4. EDUCATION: Srammar Chool Graduate Chool	1100	ndran Arminal		_	SIO OT IN	NN/QALID	
A EDUCATION: Name of School Location Dates Attended Graduate Technool UPROVAN, FIRMUNIA Yes No Independent of School Location The Province of School The Province	Spouse	cicite in the rection		5001 COIIII		0010 51121	
A. EDUCATION: Name of School Location Dates Attended Graduate						Selt-Emple	ÞΥ
A. EDUCATION: Name of School Location Dates Attended Graduate							
A. EDUCATION: Name of School Location Dates Attended Graduate	Spouse						
A. EDUCATION: Name of School Location Dates Attended Graduate							
A. EDUCATION: Name of School Location Dates Attended Graduate	Spouse						
A. EDUCATION: Name of School Location Dates Attended Graduate							
A. EDUCATION: Name of School Location Dates Attended Graduate							
Name of School Strammar School VEREVAN, ARMUNIA Yes No Deschool Initial Initial	Spouse						
Name of School Strammar School VEREVAN, ARMUNIA Yes No Deschool Initial Initial							
Standard Sta	4. ED	UCATION:					
Igh Certific School Los Angues, CA Yes No Applicant's initial Yes No Applicant's initial	Grammar			· · · · · · · · · · · · · · · · · · ·		Graduate	
Chool LCYTIMEY TIMES TO DECIDE Sollege Iniversity Yes No Decidence Applicant's initial	School	10000		in, Arnunia]	Yes No 🗆	
Yes No	School (entivey than Sch	1001 LOSF	Ingues, CA		Yes 🖸 No 🗆	
ype of degree obtained, if any College or university where obtained Applicant's initial	Jollege Jniversity	,		J ,		Yes No N	
Type of degree obtained, if any College or university where obtained Applicant's initial	Other						
College or university where obtained Applicant's initial		dagua abbiin 1 16		<u> </u>		TES LJ NO LJ	
Applicant's initial						***************************************	
	College	or university where obtained.			•••••		
						CAMA	
				•	Applicant's initial		

5 MILITARY INFORMATION: Yes □ No 💢 Have you ever served in any armed forces? 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 \(\subseteq \text{No} \subseteq \text{ If yes, furnish details on page 10. (List all incidents)} regardless of where they occurred-foreign or domestic.) В. 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.) 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 \(\sqrt{No} \) If yes, give details in space provided below. List all cases without exception. Date of Arrest Charge Location-City and State Deposition/Date Arresting Agency 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 X If yes, furnish details on Have you ever been questioned or deposed by a city, state, federal or law enforcement agency, commission C. or committee? Yes □ No 💢 Have you ever been subpoenaed to appear or testify before a federal, state or county grand jury, board or D. commission? Yes □ No 🏋 E. Have you ever been subpoenaed to testify for any civil, criminal or administrative proceeding or hearing? Yes No X 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 Have you ever received a pardon or deferred prosecution for any criminal offense? Yes ☐ No ☒ G. If yes when?_____city, county and state____ Has any member of your family or of your spouse's family ever been convicted of a felony? Yes □ No ☒ Η. If you answer to any of the above questions (B through H) is yes, furnish details on page 10.

Charge

Relationship

Name

Applicant's initial....

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

Ļ	oart to a lawş ′es □ No [uit as either a p X(Other than o	llaintiff or defendant or livorces)	ip, or owner, director or officer or an arbitration as either a claima ception, including bankruptcies:	of a corporation. ever been ant or respondent?
Plaintiff/De			Court and Case	boption, moraling bankraptores.	
Claimant/R		Date Filed	Number	City, County and State	Disposition/Date
a	ssociated wi	th it as an owne	business venture, soler, officer, director or pete the following:	le proprietorship or closely held partner) been a party to a lawsui	corporation (while you wer t, arbitration or bankruptcy
	ame of Entity		Type of Entity	Approximat Lawsuit/Art	e Date(s) of oitration/Bankruptcy
		ı have had for t	ne last 25 years:		
(From-To		Stree	and Number	City	tate or County
kan U War 9	<u> 210 - 120</u> 1210 - 120	25ent 70	<u>083 Sonw</u> Kl Motillian	ea way Las vege	95, NV 89113
<u> </u>		<u> </u>	JOI COMMON	CI (15 Veges) INV	+ 0.1131
	1100				

Applicant's initial CMM
Page 5

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. Sanara Ave LV, NV 89102
Title !	Description of Duties	Name of Supervisor
OWNER	anner	NO
Month and Year	Name/Mailing Address of Employer/Business	Reason for Leaving
Jan-2013- MAR	2015 Las Vegas Sleeplas	o. Parisarless Closed.
Title	Description of Duties	Name of Supervisor
ASSISTANT to	the owner Billing	Apnen
Month and Year	None Melling Address of Francisco	
Feb 2013 - Oct	Name/Mailing Address of Employer/Business 2016 Marketing Pariset	asveras, NV Self Employed
Title	Description of Duties	Name of Supervisor
OME.	marketing).	nla
Month and Year	Name/Mailing Address of Employer/Business	Proceedings of the Control of the Co
2009-2013	Comples Dental-LasVa	Reason for Leaving
Title	Description of Duties	Name of Supervisor
tran lesk	Front Desk, Insurance V	exitication. Another Job
Month and Year	Name/Mailing Address of Employer/Business	REACHTREASON for Leaving OPENING.
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 CMM
Page 6

9. CHARACTER REFERENCES:

	List five charae		ho have know you five yea	rs or more. Do	not include relatives, p	resent
Name of	f Where Employed	Street	City State Zip	Telephor	ne Years I	Known
Name \	John Mina	S Home	Glandale, CA	· .·		gyrs.
Employe	-Marketing	PaislBusiness	Las, Vegas, N	<u> </u>		
Name)	VICK KARD	Khanajar	1 Las Vegas, N	V	10	yes.
Employe	-Marketing	Raisausiness	Las Vegas, N	J		
Name P	tulin Man	asy adhe	Grandale, CA	· 	· · · · · · · · · · · · · · · · · · ·	byrs.
Employe	er N/a	Business	nla			1
Name 4	Jirabeth V	UNCHAMAN	Los langueles,	CA		12418
Employe	1010	Business	nia '			
Name (Jam Bed	RCS Home	Las Vegas in	V		124RS
Employe	er NO	Business	- n1a.			
10.	person's depo	ny safe deposit sitory? Yes ☐ ete the followin		ry, access to a	ny depository or do you	use any other
Box Nur	nber or Type of Dep	ository	Location City and S	tate	Authorized Users	

11.	Have you ever	held a privilege	ed, occupational or professi	onal license in	any state, including but	not limited to
	Liquor	Lawyer	Race horse/race dog ow		Securities dealer	Insurance
	Doctor Accountant Yes □ No ☒	Contractor Pilot	Real estate broker or sal Sports promoter	esman	Barber/Cosmetologist Trainer or manager	Gaming Educator
	If yes, state ty	pe, where and y	ears held			
	•••••	•••••••••	••••••			•••••
		•••••				
12.	interest in a lic If yes, state typ	ensed business be, when and when ames and addre	ty, county of state business or industry OUTSIDE the s nere and give names and to ess of all partners and the a	State of Nevada ocations of the l	a? Yes □ No ☒ ousinesses in which you	u were
		••••••		••••••••••••••••		
					<i>C</i> ::	A
				Ap	oplicant's initial GW	∕∖ Page 7
						raue /

13.	Have you ever appeared before any licensing agency or s any reason whatsoever? Yes ☐ No V	imilar authority in or outside the State of Nevada for	
14.	Have you ever been denied a personal license, permit, certificate or registration for a privileged, occupational or professional activity? Yes □ No 🕱		
If yes t	to the above, state where, when and for what reason:		
15.	Have you ever been refused a business or industry license participant in any group which has been denied a business suitability?	e or related finding of suitability or been a s or industry license or related finding of Yes □ No 又	
16.	Have you or any person with whom you have been a partical administrative action or proceeding relating to the pharma	cipant in any group been the subject of an ceutical industry? Yes □ No 🂢	
17.	Have you or any person with whom you have been a partiguilty or entered a plea of nolo contendere to any offense, controlled substances?	cipant in any group ever been found guilty, plead federal or state, related to prescription drugs and/or Yes □ No	
18.	Have you or any person with whom you have been a partice permit or certificate of registration relating to the pharmace upon voluntary close of a manufacturer	cipant in any group ever surrendered a license, sutical industry voluntarily or otherwise (other than Yes □ No 🗵	
19.	Do you have any relatives within the fourth degree of cons pharmaceutical or drug related industry?	anguinity associated with or employed in the Yes □ No 🂢	
		PH F	
********		ate of photograph 05.28-2017	
		Applicant's initial am Page 8	

STATE OF NEUADA
SS.
COUNTY OF CLARK
I, Gevora Murodyon, 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 day of

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

(seal)

Applicant's initial \(\triangle W \)

Page 9



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 Las Vegas, Nevada 89102

9171 9690 0935 0141 9726 52

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
(Flease provide current license fluttiber it making changes. Will of MVV
□ 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: LOS VEGOS Medical Store
Physical Address: 4527 N. Cahara Ave. Las Vegas, NV 99102 (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: 702-803-131015 Fax: 702-9120-931010
E-mail: Info@cosegrsMedicalStove comebsite: New lastagesMedicalState com
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: <u>10a to 5βM</u> Tue: <u>10α to 5βM</u> Wed! <u>QaMto 5βM</u> Thu: 1 <u>Qanto 5βM</u>
Fri: 1000000000000000000000000000000000000
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Ana P. Gonzalez
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)
☐ Medical Gases** ☐ Assistive Equipment
 ☐ Respiratory Equipment** ☐ Life-sustaining equipment** ☐ Orthotics and Prosethics
☐ Diabetic Supplies 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: And P. Gonzalez Telephone: 702-813-7173
Page 1

Inis	page must be submitted for all types of o	ownershi	<u>).</u>	
List	all Medicare and Medicaid provider numb	bers regis	stered to the business or	its owner:
_	$ n \alpha$	·		
		······································		
1)	Do any shareholders hold an interest of any type of business or facility which a or another political jurisdiction?	ownership are licens	o or have management in ed by the State of Nevac	n da Yes □ No ☑
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?	een assoo MDEG p	siated with any person, roducts were sold,	Yes ☑ No □
3)	Are any of the owners health profession	nals? If	yes, please check the bo	ox and list name.
	 □ Practitioner □ Advanced Practitioner of Nursing □ Physician's Assistant □ Physical Therapist □ Occupational Therapist □ Registered Nurse ☒ Respiratory Therapist 	Name: Name: Name: Name:	Ana P. Momales	

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

Board Use Only

This page must be submitted for all types of ownership.

Withir	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				
Print	Name of Authorized Person Date			

Received:

Amount: <u>\$500.00</u>

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

Owner's Name: ARMENAK MUK	'adyan
Business Name: Las Vegas Me	dical Store
Current Business Address: 4527 W. 9	Sahara Ave.
City: Las Vegas	State: _NV Zip:
Telephone: 702 - 803 - 1365	Fax: 702-920-8366

SOLE OWNER

Include with the application for a sole owner

<u>Complete personal history record</u> 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

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	121/1F			
Las Vegas Me	dical Store-4527 W.S	UDEG Chara Ave.	Las Vegas, NV	89102
Name a	and Address of Business for Whic	h MDEG Adminis	strator Is Requeste	ed .
	If applicable, Name Under W	/hich It Is Now O	perated	

A6

1. PERSONA	L INFORMATIO	ON:	
(2013	ales	(ina-	1
Last Name		First Name	Middle Name
Alias(es, Nickna	mes, Maiden N	ame, Other Name Changes, Legal	or Otherwise)
2437	Ywin	Hower Cir.	L.V. NV 89/34
Present Resider	. 10	reet or RFD City S VECKIS, NV 89102 City	State/Zip
4527 N. Sano	THE THE.	Dates Mairch 2017, 1	nesent
Present Busines		City	State/Zip
Present Position	Theremos with the MDE	STDates March 2017	
Phone: 70	2)8/3	- <u>7173</u> Fax:	
Email address:	APGL	B10 Icland, Ca	om
···			,
Date of		Place of Birth (City, County, State	·, ·
48		-	
Age (0	Social Security Number	Sex
Color of Eyes	<i>DOU</i> Color of Ha	ir Weight	56// Height
•		marks and/or characteristics	V
	area ngaren ng	marks and/or characteristics	
Are you a citizen	of the United S	States? Yes □ No □	
If alien, registrati	on No		
If naturalized, ce	rtificate No	Date	
Place		(If naturalize	

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	T Las Vegas Mudical Store / Las V Name/ Address of Employer/Business	No of Employed Hours
Spiratory Thera	nst - Phishuss Not open 49T. Description of Duties	Armenak
2013 PROSENT Month and Year PRT MONT Title 2010 - 2013 S Month and Year PRT SC Title	Name/ Address of Employer/Business TRAND COCUMENT PATIENT THEY OF Description of Duties NEW PREAMS, LOUS AND TEXES SPECIAL HOSPITAL Name/ Address of Employer/Business TUPA COCUMENT PATIENT THE	Name of Supervisor
Month and Year	MONITORY SET UP POTTENT Machinery 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 diagnos or a physical condition that would impair my license, including alcohol or substance abus	sed or treated in the last five years for a mental illness ability to perform any of the essential functions of my e,			
1. I have □ I have not been charge	ed, arrested or convicted of a felony or misdemeanor.			
	e not been the subject of an administrative action whether completed or			
 I have □ I have not □ had a license disciplined, including any action again 	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 provide a written explanation and/or docume	or 3, please include the following information and nts.			
a) Board Administrative Action:b)	State:			
5)	Date:			
	Case Number:			
c) Criminal Action:	State:			
	Date:			
	Case Number:			
	County:			
	Court:			
4. Will you be actively involved in and a operation of the MDEG?	ware of the daily			
5 .Will you be employed fulltime with the	e MDEG? Yes ☑ No □			
6 .Will you be present at the site of the during its normal operating hours?	MDEG Yes ☑ No □			
s 4, 5 or 6 pleas	e provide a written letter of explanation.			
	ATTACH PHOTOGRAPH			
	TAKEN WITHIN LAST			
	30 DAYS HERE			
The same of the sa				
Page 4 A	Date of photograph (00) 1017			
raye 4 - 1	MDEG Administrator			

A6

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

Details Page 1 of 2



NEVADA STATE BOARD OF MEDICAL EXAMINERS

Search

Licensee Details

Person Information

Ana P. Name:

GONZALEZ

2437 TWIN

Address: FLOWER

CIRCLE

Las Vegas NV 89134

Phone: 7028137173 License Information

License

Practitioner of Respiratory Care

Type:

License Number:

RC2228 Status:

Active

Issue Date: 2/22/2013 Expiration 6/30/2019

Date:

Scope of Practice

Scope of Practice: Respiratory Care

Education & Training

School: Holy Angels Academy / New Orleans, LA

High

Degree\Certificate: School

Diploma

Date Enrolled:

Date Graduated: 5/16/1984

Scope of Practice:

School: Louisiana State University / New Orleans, LA

Practitioner

of

Degree\Certificate: 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:

Details Page 2 of 2

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

Page 1

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	A	2menak -	Muradyar	\ *	
4527 N. Sa	naea Ave	. Las Vegas	of License NV 99102	- Las Veaa	is Medical Store
•	Name a	nd Address of Establish	ment for Which License	Is Requested	
***************************************		If applicable, Name Und	der Which It Is Now Ope	erated	***************************************
1. PERSONAL INF	ORMATION:	1uradyan	Armenal	4	
Last Name		First Name	9	Middle Name	
Alias(es, Nicknames, Maid	len Name, Other Nam	e Changes, Legal or Otl	herwise)		
3001 CC+il Present Residence Addres	lion ct.	Las Vegas	•	NV. 89	147
				State/	Zip
4527 10. Sah	ara Ave.	Dates 01,-2017	+-PRESENT	Lasvega	147 zip B, NV 89102
Present Business Address			City	Otoron	Zip /
DWher		Dates U3-201	7 - HROSENT	1	
Occupation			•	Phone: ~ Residence	ر د د د
		3 F	0		-806-1365
		Yerevan,	Armenia	Business TCZ	-000 1000
Date of Birth		Place of Birth (City,	County, State)		
3D					Male
Age	Social	Security Number			Sex
Brown	Brown	Fair	210	Medium	5111
Color of Eyes	Color of Hair	Complexion	Weight	Build	Height
Scars, tattoos or disti	nguishing marks	and/or characteristi	re NIA - Ni	m 0.	
		and/or characteristi	C3_117[1]	<i></i>	
Are you a citizen of th	ne United States?	Yes X No □ I	f alien, registration	No	
If naturalized, certification	ate No	••••••	Date		
Place					
		***************************************	(ii Haturaliz	zea, document mus	st be verified.)
2. MARITAL INFOR	RMATION:				
Single Married	X Separate	d □ Divorced	☐ Widowed [☐ Engaged □]
				Applicant's initial	An

MADIT	AL INFORMATION Continued				
	AL INFORMATION-Continued	ĺa	e Vogo e	AND Menal	/ Do
A.	Current Marriage 04-07-2015 Spouse's full name (Maiden) 1944/42/41 Lilit	La C	ity, County and	State	-warny
	Spouse's full name (Maiden) [4](V/12)(AV) 1. L.1.11		3.S. No _.		1
	Date of Birth Place of Bir				
	Resident address 3881 COTILION CT LOS Street	City	State	Zip	
	Telephone: Residence Bu	ısiness	UIO		
	Spouse's employer NG Occ	cupation	nla		
	Address of employer NC				
B. Pr	revious Marriages: If ever legally separated, divorced, or ann	nulled, indicate	e below:		
Name o	Date of Order Date of Place of Spouse or Decree of Marriage	Nature of Action	,	nty and State	
	nla				
	List of names, current address and telephone numbers of p	revious spouse State	Zip	Telephone	
3. FA A.	AMILY INFORMATION: Children and Dependents: List all children, including step-children and adopted ch Name Birth Date Birth Place		e the following the the following the following the the following the fo		n:
В.	Child Support Information: Please mark the appropriate response:				
	☑ I am not subject to a court order for the support of the su	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 Page 2

District afformey or public agency	roopanoible for enfancing the still					
Name	District attorney or public agency responsible for enforcing the child support order: Name					
Contact person						
C. Parents:						
List names, residence addresses	s, dates of birth and most recent occupations o	of parents, step-parents.				
parents-	d or deceased, list last address and occupatio					
Name (Maiden) Birth	n Date Address	Occupation				
Father						
uuradyan Stadran	17083 Somera Way Las Vegas,	AN DAILS SOIL DIMPION				
Mother	1 4005 agreed vary his legers,	IN BILL SELL SUPPLY				
hirodyan, Narine	7083 80ncepa Way Las Vegas,	NY 99113 - Cachier				
Father-in-Law	100 100	mo atsmore.				
nla						
Mother-in-Law						
nla						
D. Brothers and Sisters: List names, residence addresses	, dates of birth and most recent occupations o	f brothere and distance and of				
their respective spouses.						
	Birth Date Address	Occupation				
Juradyan Hevorg	7083 Simera Way Las bagas, N	N 89113-Set-Europeace				
OKA						
Spouse						
Spouse						
pouse						
4. EDUCATION:						
	Location Dates Attended					
Name of School Grammar	Location Dates Attended	Graduate				
rammar chool	Yercyan, Armunia	Graduate Yes ل ا No □				
Name of School Frammar Chool Igh Chool Chool	2 3.00 / 1					
Name of School Frammar School Igh School Almdale High & NOST Sollege	Yercyan, Armunia	Yes 【☑ No □				
Name of School Frammar School Sigh School Glandale High & Nobl ollege niversity	Yercyan, Armunia	Yes 【☑ No ☐ Yes 【※ No ☐ Yes ☐ No ☐				
Name of School Frammar Chool Igh Chool Chool Ollege Iniversity	Yerovan, Armunia Gludale, CA	Yes 【 No □ Yes 【 No □ Yes □ No □ Yes □ No □				
Name of School Frammar School Igh School Ollege Inversity Other Type of degree obtained, if any	Yercyan, Armunia	Yes ♥ No □ Yes ➤ No □ Yes □ No □ Yes □ No □				

Applicant's initial AW

5 MILITARY INFORMATION:

Α.	A. Have you ever served in any armed forces? Yes 📙 N	10 X			
	BranchDate of entry-activ	ve service			
	Date of separationType of discharge	Type of discharge			
	Rating at separationSerial nur	mber	***************************************		
	While in the military service were you ever arrested for an offense special or general court martial? Yes ☐ No ☐ If yes, furnegardless of where they occurred-foreign or domestic.)				
В.	B. Have you registered for the draft? Yes ☐ No X				
	CountyStateD	ate registered			
6. AF	ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS: (In	clude those arrests	in which you were		
A.	not convicted.) A. Have you ever been arrested, detained, charged, indicted or summ violation for any reason whatsoever, regardless of the disposition of Yes □ No ☑ If yes, give details in space provided below. List all	of the event? (Except	minor traffic citations.)		
Date of A	e of Arrest Age Charge Location-City and State	Deposition/Date	Arresting Agency		
В.	B. Has a criminal indictment, information or complaint ever been returned arrested or in which you were named as an unindicted co-party? You page 10.				
C.		al or law enforcement	agency, commission		
D.	commission? Yes □ No 🏻				
E.	Yes □ No 汉				
F.	If yes, when? city, county and s	tate			
G.					
٦.	If yes when?city, county and s Has any member of your family or of your spouse's family ever bee If you answer to any of the above questions (B through H) is yes, f	en convicted of a felo	ny? Yes □ No 📉 e 10.		
Name	me Relationship Charge	Loca	ation Date		
			*		
		Applicant's initial	An		

ARRESTS, DETENTIONS, LITIGATIONS AND ARBITRATIONS-Continued

p Y	art to a lawsui 'es □ No 🕱	t as either a pla Other than div	intiff or defendant orces)	or an arbi	tration as	s either a cl	aimant or i	poration. ever beer espondent?
lf	yes, give deta	ails below. List	all cases without e	exception,	including	g bankruptc	ies:	
	endant or espondent	Date Filed	Court and Case Number	Ci	ty, County	and State		Disposition/Date
as	ssociated with	al partnership, b it as an owner, If yes, complete	officer, director of	sole propri r partner) t	etorship been a pa	or closely harty to a lav	eld corpor vsuit, arbiti	ation (while you wration or bankrupto
N	Name of Entity Type of Entity Lawsuit/Arbitration/E			s) of Bankruptcy				
					-			
RESI	DENCES:			7. 2024				
		nave had for the	last 25 years:					
th and Y rom-To)		Street an	d Number		City		State or C	County
09	-2009	524	E Acaua	1 AVE.	Glei	ndale	CAC	11205
09-	2014	7093	Donera	Way	Las	Veclas	NV	89113
14-	Proser	T 3881	Cotillion	CT!	Las	Vegas	S, NV	89147
								
			<u> </u>	-				
						Applicant	'a initial	Ann
						ryphicalli	o mandi	Pag

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-Prosent	Las Verps Medical Stoke 4527 W. Sana	va Ave. Las Vegas, NV 89102
OWNUK.	Description of Duties OLOLUZ	Name of Supervisor
Month and Year MAY 2015 - DC 2014 Title	Name/Mailing Address of Employer/Business CPAP STORE LUS VEUS 4533 W. SANAW Description of Duties	Reason for Leaving 1 TIP. LOS VEYOS, NV GAIOZ/ PESSYND Name of Supervisor
Assistant	Assistant to Owner.	Gerorgo
Month and Year LOCG - 2016 Title	Name/Mailing Address of Employer/Business Description of Duties	Reason for Leaving Shame of Supervisor
marketing	n Marketings	allex.
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

Page 6

Applicant's initial...

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

9. CHARACTER REFERENCES:

	List five charac employer or en	cter reference w	ho have know you five	years or more. [o not include relati	ves, present
Name of	Where Employed	Street	City State Zip	Teleph	none	Years Known
Name	260 KOHUKI	M Home La	s Vegas, NV			
Employe	rSelf-tmplo	YldBusiness	Bondy Shop	•		
NameA	PHYUR Steph	MN Stome La	s Vegas, NV			10
Employe	Self-tomple	169 Business	Brook Shop.			
Name	Hael Shanaa	Vit Home L	as Vegas NV	•,		20
Employe	SOFTMADE	NedBusiness	UBER-Trans	portation	<u> </u>	
Name∯	<u>ovaluss Balza</u>	VanHome La	N /			12
Employe	Self-Emplo	Ve Business T	ransportation	\sim \sim		
\sim		tuknbiran	Las Vegas, NI			9,
Employe	Selfamplo	VY Apodiness T	Zody Shop			
10.	If yes, comple	itory? Yes L Nate the following	box or other such depo No 凶 g:	sitory, access to	any depository or c	o you use any other
Box Num	ber or Type of Depo	sitory	Location City a	nd State	Authorized Users	
11.	Have you ever the following: Liquor Doctor Accountant Yes \(\sqrt{N} \) No \(\sqrt{X} \) If yes, state type	Lawyer Contractor Pilot	d, occupational or profe Race horse/race dog Real estate broker or Sports promoter ears held	owner	n any state, includir Securities deale Barber/Cosmeto Trainer or mana	r Insurance ologist Gaming
12.	interest in a lice If yes, state type	ensed business e, when and wh imes and addre	y, county of state busing or industry OUTSIDE the ere and give names an ss of all partners and the	ne State of Nevac d locations of the	da? Yes □ No 🍳 businesses in whi	ch vou were
••••				F	Applicant's initial	AM Page 7

13.	Have you ever appeared before any licensing agencany reason whatsoever? Yes □ No 💢	y or similar authority in or outside the State of Nevada for
14.	Have you ever been denied a personal license, perm or professional activity? Yes □ No 💢	nit, certificate or registration for a privileged, occupational
f yes t	o the above, state where, when and for what reason:	
15.	Have you ever been refused a business or industry I participant in any group which has been denied a bu suitability?	icense or related finding of suitability or been a siness or industry license or related finding of Yes □ No ★
16.	Have you or any person with whom you have been a administrative action or proceeding relating to the ph	
17.		a participant in any group ever been found guilty, plead fense, federal or state, related to prescription drugs and/or Yes ☐ No ※
18.		a participant in any group ever surrendered a license, irmaceutical industry voluntarily or otherwise (other than Yes No No
19.	Do you have any relatives within the fourth degree of pharmaceutical or drug related industry?	of consanguinity associated with or employed in the Yes □ No ☒
		PH
		Date of photograph 05-28-201+ Applicant's initial Avv

STATE OF Nevada	
A.I. ss.	
county of Clark	
foregoing application and know the contents thereof; that the secontain a full and true account of the information requested; the misrepresentation or failure to reveal information requested may a manufacturer license; that I am voluntarily submitting this applications of the application of permit if the holder or applicant "Has obtained and of an application, or any record, affidavit or other information information, or any record, affidavit or other information information, that I have familiarized myself with the contents of Nev Controlled Substances Act, as amended, and the Regulations promulgated thereunder and agree, if licensed, to abide thereby expressly waive, release and forever discharge agents from any and all manner of action and causes of action can, shall or may have against the State of Nevada, the licensifor a manufacturer license in the State of Nevada.	at I executed this statement with the knowledge that ay be deemed sufficient case for denial or revocation of plication with full knowledge that Nevada Revised lication of any person for a certificate, license, my certificate, certification, license or permit by the filing a support thereof, which is false of fraudulent," and ada Statutes on Pharmacists and Manufacturer and the of the Nevada State Board of Manufacturer as by, ge the State of Nevada, the licensing agency and their whatsoever which I, my administrators or executors
	Original Signature of Applicant
Subscribed and Sworn to before me this 12th day of June 2017 by Armenak Motaly Public	ALICA I CTENHALIS
	(seal)

MOEG 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

Application made so printed legisly of 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.

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
MDEG Name: RELIANT MFDICAL GROUP, LLC Physical Address: 311 S. VALLEY VIEW BLVD #A-220 NV 89102 (This must be a business address, we can not issue a license to a home address) Mailing Address: 983(VENUS LAKE COURT LAS
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 & reliantmedical supply. com Website: www reliantmedicalsupply. com
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING
Mon: 9am to 5pm Tue: 9am to 5pm Wed: 1am to 5pm Thu: 1am to 5pm Cluse Fri: 9am to 5pm Sat: to Sun: to Holidays: to xmxs, easter
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)
Name: Elaine Cardemas-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: ☐ Other: ☐ Diabetic Supplies
**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: Telephone:
Page 1 6727.8

<u>This</u>	page must be submitted for all types of o	wnership. Now		
List a	II Medicare and Medicaid provider numb	ers registered to the b	ousiness or its owner:	
				
1)	Do any shareholders hold an interest of any type of business or facility which a or another political jurisdiction?	•	_	×
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?			, X
3)	Are any of the owners health profession	nals? If yes, please o	heck the box and list nan	ne.
	 □ Practitioner □ Advanced Practitioner of Nursing □ Physician's Assistant □ Physical Therapist □ Occupational Therapist □ Registered Nurse □ Respiratory Therapist 	Name: Name: Name: Name:	U/A	

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

This page must be submitted for all types of ownership.

Withir	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 🄀
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 an interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?	y Yes □ No 💢
5)	Has the corporation, any owner(s), shareholder(s) or partner(s) with an interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?	y
attach	answer to questions 1 through 5 is "yes", a signed statement of explanated. Copies of any documents that identify the circumstance or contain a ter disposition may be required.	ition must be an order, agreement,
Lunde	by certify that the answers given in this application and attached documentation are that any infraction of the laws of the State of Nevada regulating the operized MDEG provider or wholesaler may be grounds for the revocation of this process.	eration of an
penal hereb any ir reputa	e read all questions, answers and statements and know the contents thereof. It yof perjury, that the information furnished on this application are true, accuratly authorize the Nevada State Board of Pharmacy, its agents, servants and empressigation(s) of the business, professional, social and moral background, quantion, as it may deem necessary, proper or desirable.	e and correct. I aployees, to conduct alification and
	nal Signature of Person Authorized to Submit Application, no copies or s	tamps
	Name of Authorized Person October 12/17 Date	
Boar	d Use Only Received: Amount: 4500	.00

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, LC	
Current Business	Address: 3111 S. VALLEY VIEW BLVD #A-220	
City: Las 1	1956 State: NV Zip: 89102	
Telephone: 702	-719-9092 Fax: 800-340-2955	

SOLE OWNER

Include with the application for a sole owner

<u>Complete personal history record</u> 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

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 edulpment provider	
3111 S. VALLEY VIEW BIND. A-220 LAS NEGAS NV 89102	
Name and Address of Business for Which MDEG Administrator is Requested RELIGIT MEDICAL GROUP U.C. dbg Religint Medical	/ <u>.</u>
If applicable, Name Under Which It Is Now Operated	SUPPLY

1. PERSONAL INFORMATION:		
Cardenas - Sm Hh Last Name	E(a) V First Name	<u>Jane</u> Middle Name
Elaine Jane Cardeno		widdle Mairie
Alias(es, Nicknames, Maiden Name, C		Lor Otherwise)
		orain-
VENUS CHIE CHE	DED VIGORS 100	0 1 7 8
Present Residence Address-Street or SILL S VAILED VIEW BIVE US Date	RFD 89102 City es 6/30/16 - P City	State/Zip
Present Business Address	City	State/Zip
Present Position with the MDEG	1 1 (re sent
Phone: 702-719-9042	Fax:	40-2955
Email address: Esmith Dr	eliantimedical supp	Ply.com
Ma	miky Philippines	
Date of Birth Place	ce of Birth (City, County, Sta	ate)
35		<u>Female</u> Sex
Age Soc	cial Security Number	Sex
Brown Brown	140	51
Color of Eyes Color of Hair	Weight	Height
Scars, tattoos or distinguishing marks		
"carpediem" left wir	te "T" on p	sight wrist
Are you a citizen of the United States	(CV055)	
If alien, registration No		
If naturalized, certificate No	Date	
Place	(If naturali	zed, 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.

DILAL MEDICAL - US VEGS** Fice shut down

	KEHAB MEDICAL - US 15	
5115-6/16	40-6365 Castleplate Dr. Indianapolis, IN 46250	1800 t
Month and Year	Name/Address of Employer/Business worked worketing and sales in Patients Dr's, PT's, Huspitals, Clinics	No of Employed Hours
Sales-Acct mar.	Dr's, PT's, Huspitals, Clinics	John Stags, Kerth, Lie
Title	Description of Duties	Name of Supervisor
8/13-Present	Labtest certification Inc. 3255 fepper Lane Las Veyas NV 89120	6500+
Month and Vaar	Name/ Address of Employer/Business Sales on testing and certification	No of Employed Hours
Sches- Acit My	on electrical safety manufacturing.	Name of Supervisor
Title	Description of Duties medical tempment knowledge of medical products before it reaches the clinics and dr's offices	'Name of Supervisor
6/30/16-Present	Reliant medical supply	700 t
Month and Year	Name/ Address of Employer/Business marketing / Product research / and sales of Wedical Supplies	No of Employed Hours
President		Self-
Title	Description of Duties and & Duprit	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
		No. (5 - do de
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 diagnose or a physical condition that would impair my allicense, including alcohol or substance abuse,	bility to perform any of the essential	a mental illness functions of my
1. I have □ I have not k been charged	, arrested or convicted of a felony or	misdemeanor.
 I have □ I have not been the subject pending. 	ect of an administrative action wheth	er completed o
3. I have □ I have not had a license disciplined, including any action agains	suspended, revoked, surrendered or t a professional license that was not	otherwise made public.
If you checked "I have" to questions 1, 2 and/o provide a written explanation and/or documen		rmation <u>and</u>
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 avoperation of the MDEG?	ware of the daily	Yes 🏿 No □
5 .Will you be employed fulltime with the	MDEG?	Yes 🂢 No □
6 .Will you be present at the site of the fluoring its normal operating hours?	MDEG	Yes X No □
If you answer No to questions 4, 5 or 6 please	e provide a writte	
	Date c	3
Page 4 – 1\	MDEG Administr	

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.

- 0119

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					
(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.					
Please check box for type of ownership and complete correct part of the application.					
r lease check box for type of ownership and complete contest part of the application.					
GENERAL INFORMATION to be completed by all types of ownership					
DELLANT MEDICAL COOLIN LICE					
Physical Address: 311 S Valley VIEW Blud #A 220 Las Vegas NV 87102 (This must be a business address, we can not issue a license to a home address)					
Physical Address: 311 S Valley View Blvd # A Zau GD 13					
(This must be a business address, we can not issue a license to a home address)					
Mailing Address. 9831 VANUS LAKE COURT					
City: State: _NV Zip Code: & 1178					
Telephone: 702-719-9042 Fax: 800-340-2953					
Telephone: 70 Tax					
E-mail: esmith a relicationedical supply-con Website: www-teliantmedical supply con					
DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING					
Mon: Jun to Jun Tue: Jun to Holidays:					
approning close delidered to					
Fri: Chun to JPM Sat: to Holidays to Xmas, Easter					
MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)					
Name: Claime Cardonas - Smith					
Name:					
TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)					
×					
☐ Medical Gases** ☐ Assistive Equipment ☐ Report of Entered Equipment**					
☐ Respiratory Equipment** ☐ Parenteral and Enteral Equipment**					
☐ Life-sustaining equipment** ☐ Orthotics and Prosethics Other:					
Diabetic Supplies **If providing these types of services you are required to have in place a mechanism to ensure					
continued care in the event of an emergency. Provide name and telephone number of Nevada					
contact. Name: Telephone:					
Page 1					

97252

<u>This</u>	page must be submitted for all types of o	wnership.	none	
List a	all Medicare and Medicaid provider numb	ers register	ed to the business or	its owner:
		·		
				
1)	Do any shareholders hold an interest of any type of business or facility which a or another political jurisdiction?			
2)	Are you or have you in the last year be business or health care entity in which dispensed or distributed?			Yes □ No 🛣
3)	Are any of the owners health profession	nals? If yes	s, please check the bo	ox and list name.
	 □ Practitioner □ Advanced Practitioner of Nursing □ Physician's Assistant □ Physical Therapist □ Occupational Therapist □ Registered Nurse □ Respiratory Therapist 	Name: Name: Name: Name:		

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

This page must be submitted for all types of ownership.

Within	the	last	five	(5)	years:
--------	-----	------	------	-----	--------

Board	I Use Only Received:	Amount:	500.00		
Print	Name of Authorized Person	Date			
	aine Cardenas-Smith	5/10/1			
Ørigir	nal Signature of Person Authorized to Submit Applicati	on, no copie	es or stamp	s	
any in reputa	vestigation(s) of the business, professional, social and montion, as it may deem necessary, proper or desirable.	rai backgrour	id, quaiilica	uon and	
penalt hereb	read all questions, answers and statements and know the y of perjury, that the information furnished on this application authorize the Nevada State Board of Pharmacy, its agentication (a) of the business, professional, social and more	on are true, a ts, servants a	accurate and and employed	d correct ees, to c	. 1
Lunde	by certify that the answers given in this application and attar rstand that any infraction of the laws of the State of Nevad rized MDEG provider or wholesaler may be grounds for the	la regulating t	the operatio	n of an	d correct.
attach	answer to questions 1 through 5 is "yes", a signed stated. Copies of any documents that identify the circumser disposition may be required.	atement of ex stance or co	xplanation ntain an or	must be der, ag	e reement,
5)	Has the corporation, any owner(s), shareholder(s) or interest, ever surrendered a license, permit or certific voluntarily or otherwise (other than upon voluntary cleans).	cate of regis	44:	Yes □	No D
4)	Has the corporation, any owner(s), shareholder(s) or interest, ever been found guilty, pled guilty or entere contendere to any offense federal or state, related to substances?	d a plea of r	nolo	Yes □	No S
3)	Has the corporation, any owner(s), shareholder(s) or interest, ever been the subject of an administrative acrelating to the pharmaceutical industry?	partner(s) w ction or proc	aadina	Yes □	No X
2)	Has the corporation, any owner(s), shareholder(s) or any interest, ever been denied a license, permit or ce registration?			Yes □	No X
1)	Has the corporation, any owner, shareholder(s) or pa any interest, ever been charged, or convicted of a felo misdemeanor (including by way of a guilty plea or no	ony or gross		′es □	No X

	_						
Owner's N	ame: Ele	aine Carden	us-Smith			-	
Business N	Name: <u>Le l /</u>	ant modi	cal Group	P, UC			
		ess: 3111 5 L				las voyas	89102
	s vegas		State: <u>N</u>		_		
Telephone	: 702-7	19-9042		Fax: _	800 -3	40-2955	

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

SOLE OWNER

Include with the application for a sole owner

<u>Complete personal history record</u> 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

St 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	- Distrtibutor	- In note safer
	· · · · · · · · · · · · · · · · · · ·	Nature of MDEG	s Marker Al. (80105
	VALLEY VIEW BI			
Name	and Address of Busin	ness for Which MDEG	Administrator is	Requested
•••••	RELIANT MEDICA	C GIROUP CAL CIP	a reliant 11	valed supply
	it applicable, Na	ame Under Which It Is	Now Operated	J

1. PERSONAL INFORMA	HON:		
Cardenas-Smith	Elaine		Jane
Last Name	First Name	е	Middle Name
Elaine Sane Ca			
Alias(es, Nicknames, Maider	າ Name, Other Name C	hanges, Legal or Oth	erwise)
•	onet Las vigas		
Present Residence Address 311 5 Valley VIEW BIVE # Present Business Address	Street or RFD A-2z0 Dates 6/30	City 116 - Present	State/Zip
Present Business Address		City	State/Zip
frésident-		16 - Present	
Present Position with the M			
Phone: 702-719-90	42 Fax	: 800-340-	2954
Phone: 702-719-90. Email address: esmith?	d reliantmedical	supply can	
	Manila, Phi	lippines	
Date of Birth	Place of Birth (Cit	ty, County, State)	
35	_		Female
Age	Social Security N	umber	Sex
Brown Bron	m 14	D EK	57
Color of Eyes Color of	Hair We	ight	Height
Scars, tattoos or distinguish	ing marks and/or chara	cteristics	
"Carpe diem" left wris	t - cross"=	e" right wrist	
Are you a citizen of the Unit	Α		
If alien, registration No			
If naturalized, certificate No		Date	
Place			cument 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

	MD MEMICAL	
1/15-6/16 Ha	-6365 Castlephice Dr. Indianapolis IN, 4625	
Month and Year	Name/ Address of Employer/Business at Hospitals, PT, and Dr. effices m	No of Employed Hours
Siles-Act Mar		John Skaggs, Keith, Vick
Title	Description of Duties	Name of Supervisor
	LABITST CENTIFICATION IN	
8/13- Present	3255 Pepper LANE NV 891120	4500+ hrs.
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Sales Acitings.	Dealt w/ electrical safety testing and contification of medical ecuipment some	nufactured Robert GraDu
Title .	Description of Duties	Name of Supervisor
, (32/16 - Present	Rehant medical Supply	
, (30)10	Fehral medical supply 3111 sualley view Blud A-220 3111 sualley Las voys NV 89102	700+
Month and Year	Name/ Address of Employer/Business,	No of Employed Hours
president	sole) of medical supplies & ecuipment	Self-
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
Title	Description of Duties	Name of Supervisor
Month and Year	Name/ Address of Employer/Business	No of Employed Hours
 Title	Description of Duties	Name of Supervisor

I have \Box I have not \Box been diagnos or a physical condition that would impair my license, including alcohol or substance abuse	ability to perform any of the essentia	or a mental illness Il functions of my	
1. I have □ I have not been charge	ed, arrested or convicted of a felony of	or misdemeanor.	
 I have □ I have not \(\subseteq \) been the subsete pending. 	oject of an administrative action whe	ther completed or	
3. I have ☐ I have not ☐ had a license disciplined, including any action again	e suspended, revoked, surrendered ast a professional license that was no	or otherwise ot made public.	
If you checked "I have" to questions 1, 2 and provide a written explanation and/or docume		formation <u>and</u>	
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 operation of the MDEG?	aware of the daily	Yes X No □	
5 .Will you be employed fulltime with th	ne MDEG?	Yes 🗶 No □	
6 .Will you be present at the site of the during its normal operating hours?	MDEG	Yes ⋈ No □	
If you answer No to questions 4, 5 or 6 plea	ise provide a written letter of explana	ation.	
	Date	2	
Page 4 -	- MDEG Adminis	M	

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