



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
Medical Use of Marijuana Program
99 Chauncy Street, 11th Floor, Boston, MA 02111

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-860-6370
www.mass.gov/medicalmarijuana

APPLICATION OF INTENT
Request for a Certificate of Registration to
Operate a Registered Marijuana Dispensary

INSTRUCTIONS

This application form is to be completed by any non-profit corporation that wishes to apply for a Certificate of Registration to operate a Registered Marijuana Dispensary ("RMD") in Massachusetts.

If seeking a Certificate of Registration for more than one RMD, the applicant non-profit corporation ("Corporation") must submit a separate *Application of Intent*, all required attachments, and an application fee for each proposed RMD. Please identify each application of multiple applications by designating it as Application 1, 2 or 3 in the header of each application page. Please note that no executive, member, or any entity owned or controlled by such an executive or member, may directly or indirectly control more than three RMDs.

However, even if submitting an *Application of Intent* for more than one RMD, an applicant need only submit one *Character and Competency form* for each required individual.

Unless indicated otherwise, all responses must be typed into the application forms. Handwritten responses will not be accepted. Please note that character limits include spaces.

Attachments should be labelled or marked so as to identify the question to which it relates.

Each submitted application must be a complete, collated response, printed single-sided, and secured with a binder clip (no ring binders, spiral binding, staples, or folders).

Mail or hand-deliver the *Application of Intent*, with all required attachments, the \$1,500 application fee, and Remittance Form to:

Department of Public Health
Medical Use of Marijuana Program
RMD Applications
99 Chauncy Street, 11th Floor
Boston, MA 02111

Application fees are non-refundable and non-transferable.

MA Dept of Public Health
99 Chauncy Street
Boston, MA 02111

SEP 22 2015

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Application 3 of 3 Applicant Non-Profit Corporation _____**CHECKLIST**

The forms and documents listed below must accompany each application, and be submitted as outlined above:

- ☒ A fully and properly completed *Application of Intent*, signed by an authorized signatory of the corporation
- ☒ A copy of the Corporation's *Certificate of Legal Existence* from the Massachusetts Secretary of State
- ☒ Financial account summary(ies) (as outlined in Section D)
- ☒ A bank or cashier's check made payable to the *Commonwealth of Massachusetts* for \$1,500.
- ☒ A completed *Remittance Form* (use template provided)
- ☒ A completed and signed *Character and Competency* form (use template provided) for each of the following actors:
 - Chief Executive Officer; Chief Operating Officer; Chief Financial Officer; individual/entity responsible for marijuana for medical use cultivation operations; individual/entity responsible for the RMD security plan and security operations; each member of the Board of Directors; each Member of the Corporation, if any; and each person and entity known to date that is committed to contributing 5% or more of initial capital to operate the proposed RMD. For entities contributing initial capital to operate the proposed RMD, the *Character and Competency* Form must be completed and signed by the entity's Chief Executive Officer/Executive Director and President/Chair of the Board of Directors.

MA Dept of Public Health
99 Chauncy Street
Boston, MA 02111

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Information on this page has been reviewed by the applicant, and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: SEA

SECTION A. APPLICANT INFORMATION

1. DO Health Massachusetts, Inc.
Legal name of Corporation
2. Steven Addison
Name of Corporation's Chief Executive Officer
3. 109 State Street, Suite 404, Boston, MA 02109
Address of Corporation (Street, City/Town, Zip Code)
4. Steven Addison
Applicant point of contact (name of person the Department should contact regarding this application)
5. 303-250-3651
Applicant point of contact's telephone number
6. sbaddison@gmail.com
Applicant point of contact's e-mail address
7. Number of applications: How many *Applications of Intent* do you intend to submit? 3

SECTION B. INCORPORATION

8. Attach a *Certificate of Legal Existence* from the Massachusetts Secretary of State, documenting that the applicant non-profit entity is incorporated as a non-profit in Massachusetts.

SECTION C. CHARACTER AND COMPETENCY

9. Attach a *Character and Competency* form (use template provided) for each of the following actors:
 - The Chief Executive Officer; Chief Operating Officer; Chief Financial Officer; individual/entity responsible for marijuana for medical use cultivation operations; individual/entity responsible for the RMD security plan and security operations; each member of the Board of Directors; each Member of the Corporation, if any; and each person and entity known to date that is committed to contributing 5% or more of initial capital to operate the proposed RMD. For entities contributing initial capital to operate the proposed RMD, the *Character and Competency* Form must be completed and signed by the entity's Chief Executive Officer/Executive Director and President/Chair of the Board of Directors.

Information on this page has been reviewed by the applicant, and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: SAH


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 MA Dept of Public Health
 89 Charlestown Street
 Boston, MA 02111

Application 3 of 3 Applicant Non-Profit Corporation _____**SECTION D. INITIAL CAPITAL REQUIREMENT**

Describe the sources, types, and amounts of required initial capital in the table below, showing that the Corporation has at least \$500,000 in its control and available for this *Application of Intent* and at least \$400,000 in its control and available for each additional *Application of Intent*, if any, as evidenced by bank statements, lines of credit, or financial institution statements. Add more tables if needed.


If the required funds are being held in an account in the name of an individual or entity other than the Corporation, the individual or authorized signatory of the entity must provide their signature in the "Signature of Account Holder" column. Their signature below indicates that they are committing the amount of their funds identified in the table to the applicant.

In addition to completing this table, submit a **one-page** financial account summary for each account listed below documenting the available funds, dated no earlier than 30 days prior to the date the *Application of Intent* was submitted to the Department.

Name on Account	Financial Institution	Type of Account	Amount	Signature of Account Holder
Glenn Weinberg & Debra Weinberg	Deutsche Asset & Wealth Management	Brokerage Account	\$ 400,000.00	
-----	-----	TOTAL:	\$ 400,000.00	---

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August 26, 2015

Mr. Glenn Weinberg
Mrs. Debra Weinberg


Barry L. Garber
Managing Director
Client Advisor

Deutsche Bank Securities Inc.
100 International Drive 22nd Floor
Baltimore, MD 21202

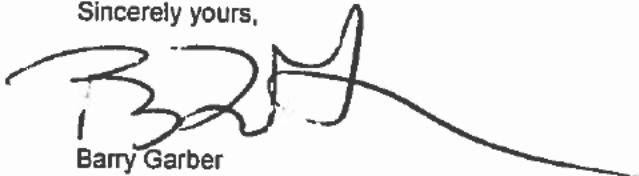
Tel 410 895 3971
Fax 443 992 7930
Toll Free 800 638 2596
barry.l.garber@db.com

RE: Your Deutsche Bank Account

Dear Glenn and Debra:

You have requested, and we are herein providing, verification that you maintain brokerage account balances with Deutsche Bank Securities Inc. ("DBSI") in excess of \$2,000,000 as of August 26, 2015. Please be advised that your balances are subject to market fluctuation, withdrawals, and/or transfers. As you know, you have been a valued client of DBSI since 1997.

Sincerely yours,



Barry Garber
Managing Director
Client Advisor
Tel: (410) 895-3971
Fax: (443) 992-7930

The above information concerning the status of the relationship is made as of the date of this letter only and DBSI assumes no responsibility to update or correct any information stated herein; DBSI assumes no responsibility for the accuracy or inaccuracy of any statement herein; and no liability shall attach to DBSI or any of its subsidiaries and/or affiliates or its officers, directors, employees or agents in relation to this document.

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Confidential

Application 3 of 3 Applicant Non-Profit Corporation _____**ATTESTATIONS**

Signed under the pains and penalties of perjury, I, the authorized signatory for the applicant non-profit corporation, agree and attest that all information included in this application is complete and accurate and that I have an ongoing obligation to submit updated information to the Department if the information presented within this application has changed.

STEVEN ADDISON
Signature of Authorized Signatory

9/21/15
Date Signed

Steven Addison

Print Name of Authorized Signatory

Chief Executive Officer, DO Health Massachusetts, Inc.

Title of Authorized Signatory

I hereby attest that if the non-profit corporation is allowed to proceed to submit a *Management and Operations Profile*, the applicant non-profit corporation is prepared to pay a non-refundable application fee of \$30,000 and the cost of all required background checks, and comply with all *Management and Operations Profile* and *Siting Profile* requirements.

STEVEN ADDISON
Signature of Authorized Signatory

9/21/15
Date Signed

Steven Addison

Print Name of Authorized Signatory

Chief Executive Officer, DO Health Massachusetts, Inc.

Title of Authorized Signatory

I hereby attest that I understand that registered marijuana dispensaries are required to conduct background investigations of proposed Dispensary Agents, that such background investigations are subject to the Department's inspection and review, and that the applicant non-profit corporation will not engage the services of a Dispensary Agent that has ever been convicted of a felony drug offense in Massachusetts, or a like violation of the laws of another state, the United States, or a military, territorial, or Indian tribal authority.

STEVEN ADDISON
Signature of Authorized Signatory

9/21/15
Date Signed

Steven Addison

Print Name of Authorized Signatory

Chief Executive Officer, DO Health Massachusetts, Inc.

Title of Authorized Signatory

Information on this page has been reviewed by the applicant, and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: SBA



William Francis Galvin
Secretary of the
Commonwealth

The Commonwealth of Massachusetts
Secretary of the Commonwealth
State House, Boston, Massachusetts 02133

Date: September 09, 2015

To Whom It May Concern :

I hereby certify that

DO HEALTH MASSACHUSETTS, INC.

appears by the records of this office to have been incorporated under the General Laws of this

Commonwealth on **August 20, 2015** (Chapter 180).

I also certify that so far as appears of record here, said corporation still has legal existence.



In testimony of which,

I have hereunto affixed the

Great Seal of the Commonwealth

on the date first above written.

William Francis Galvin

Secretary of the Commonwealth

Certificate Number: 15095183010

Verify this Certificate at: <http://corp.sec.state.ma.us/CorpWeb/Certificates/Verify.aspx>

Processed by: jmu