



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, 11<sup>th</sup> Floor, Boston, MA 02111

RECEIVED

OCT 12 2017

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

CHARLES D. BAKER  
Governor

KARYN E. POLITO  
Lieutenant Governor

MARYLOU SUDDERS  
Secretary

MONICA BHAREL, MD, MPH  
Commissioner

Tel: 617-660-6370  
[www.mass.gov/medicalmarijuana](http://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 a non-profit corporation or domestic business corporation that wishes to apply for a Certificate of Registration to operate a Registered Marijuana Dispensary ("RMD") in Massachusetts ("applicant").

If seeking a Certificate of Registration for more than one RMD, the applicant 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 labeled or marked so as to identify the question to which it relates.

Each submitted application must be a complete, collated response, printed single-sided on 8 1/2" x 11" paper, 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, 11<sup>th</sup> Floor  
 Boston, MA 02111

**Application fees are non-refundable and non-transferable.**

Application 3 of 3 Name of Applicant Corporation Northeast Alternatives, Inc.

## REVIEW

Applications are reviewed in the order they are received.

After a completed application packet and fee is received by the Department of Public Health ("Department"), the Department will review the information and will contact the applicant if clarifications or updates to the submitted application materials are needed. The Department will notify the applicant whether it has met the standards necessary to be invited to submit a *Management and Operations Profile*.

If invited by the Department to submit a *Management and Operations Profile*, the applicant must submit the *Management and Operations Profile* within 45 days from the date of the invitation letter, or the applicant must submit a new *Application of Intent* and fee in order to proceed in the application process. Applicants must receive an invitation from the Department to submit a *Siting Profile* within 1 year of the date of submission of the *Management and Operations Profile*.

## PROVISIONAL CERTIFICATE OF REGISTRATION

Applicants must receive a Provisional Certificate of Registration from the Department within 1 year of the date of the invitation letter from the Department to submit a *Siting Profile*. If the applicant does not meet this deadline, the application will be considered to have expired. Should the applicant wish to proceed with obtaining a Certificate of Registration, a new application must be submitted, beginning with an *Application of Intent*, together with the associated fee.

## REGULATIONS

For complete information regarding registration of an RMD, please refer to 105 CMR 725.100, as well as materials posted on the Medical Use of Marijuana Program website: [www.mass.gov/medicalmarijuana](http://www.mass.gov/medicalmarijuana).

It is the applicant's responsibility to ensure that all responses are consistent with the requirements of 105 CMR 725.000, et seq., and any requirements specified by the Department, as applicable.

## PUBLIC RECORDS

Please note that all application responses, including all attachments, will be subject to release pursuant to a public records request, as redacted pursuant to the requirements at M.G.L. c. 4, § 7(26).

## QUESTIONS

If additional information is needed regarding the RMD application process, please contact the Medical Use of Marijuana Program at 617-660-5370 or [RMDapplication@state.ma.us](mailto:RMDapplication@state.ma.us).

Application 3 of 3 Name of Applicant Corporation Northeast Alternatives, Inc.




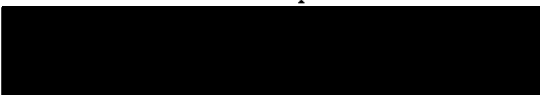
## CHECKLIST

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 applicant
- A copy of the applicant's *Certificate of Legal Existence* (as outlined in Section B)
- A completed and signed *Character and Competency* form for each required actor (as outlined in Section C)
- Financial account summary(ies) (as outlined in Section D)
- A completed *Remittance Form* (use template provided)
- A bank or cashier's check made payable to the *Commonwealth of Massachusetts* for \$1,500

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

**SECTION A. APPLICANT INFORMATION**

1. Northeast Alternatives, Inc.  
Legal name of Applicant Corporation
  
2.   
Mailing address of Applicant Corporation (Street, City/Town, Zip Code)
  
3.   
Applicant Corporation's point of contact (the person the Department should contact regarding this application)
  
4.   
Point of contact's telephone number
  
5.   
Point of contact's e-mail address
  
6. Number of applications: How many *Applications of Intent* does the applicant intend to submit?  
3

**SECTION B. INCORPORATION**

7. Attach a *Certificate of Legal Existence* from the Massachusetts Secretary of the Commonwealth, documenting that the applicant is incorporated as a non-profit corporation or domestic business corporation in Massachusetts.

**SECTION C. CHARACTER AND COMPETENCY**

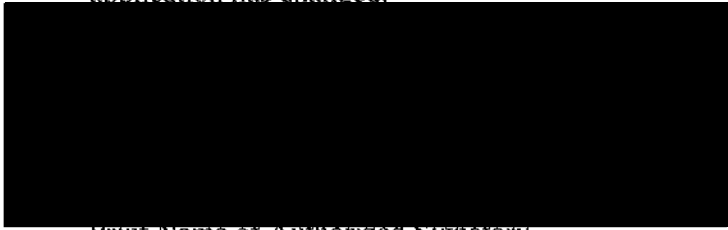
8. Attach a completed and signed *Character and Competency* form (use template provided) for each required actor (as outlined in the *Character and Competency* form).



Application <sup>3</sup> of <sup>3</sup> Name of Applicant Corporation

**ATTESTATIONS**

Signed under the pains and penalties of perjury, I, the authorized signatory for the applicant, 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.



10/11/2017

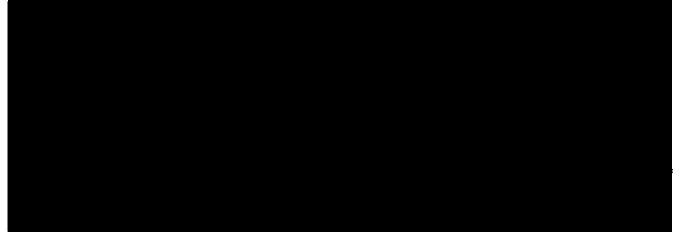
Date Signed

Print Name of Authorized Signatory

CFO/Treasurer/Clerk/Member/Director

Title of Authorized Signatory

I, the authorized signatory for the applicant, hereby attest that if the applicant is allowed to proceed to submit a *Management and Operations Profile*, the applicant 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.



10/11/2017

Date Signed

Print Name of Authorized Signatory

CFO/Treasurer/Clerk/Member/Director

Title of Authorized Signatory

Application 3 of 3 Name of Applicant Corporation Northeast Alternatives, Inc.

**ATTESTATIONS**

Signed under the pains and penalties of perjury, I, the authorized signatory for the applicant, 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.



10/11/2017

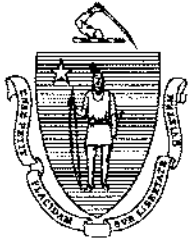
Date Signed

Print Name of Authorized Signatory

CFO/Treasurer/Clerk/Member/Director

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: ■



William Francis Galvin  
Secretary of the  
Commonwealth

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

Date: October 10, 2017

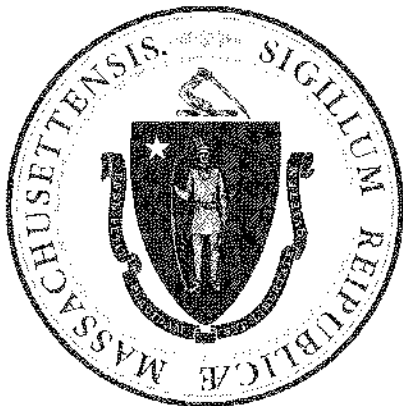
To Whom It May Concern :

I hereby certify that

**NORTHEAST ALTERNATIVES, INC.**

appears by the records of this office to have been incorporated under the General Laws of this Commonwealth on **December 13, 2016** (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: 17100172650

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

Processed by:



BNY MELLON  
WEALTH MANAGEMENT

Jonathan D. DiPaolo  
Vice President, Senior Director

October 2, 2017

[REDACTED]

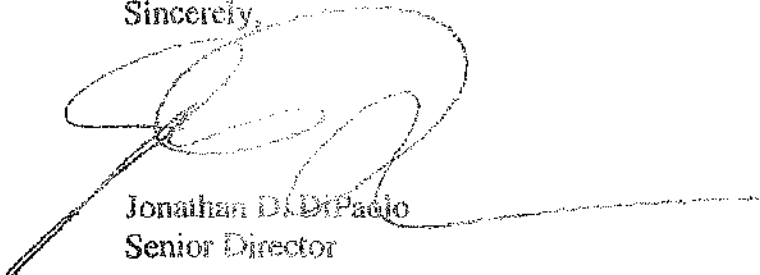
To whom it may concern:

[REDACTED] has an investment management account in which BNY Mellon serves as the investment manager [REDACTED] is the sole trustee and beneficiary. The name of the account is [REDACTED]

As his Portfolio Officer, I can verify that [REDACTED] has liquid assets and funds with a market value in excess of \$1,300,000.

Please let me know if I can be of further assistance.

Sincerely,

  
Jonathan D. DiPaolo  
Senior Director