



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

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

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

RECEIVED  
SEP 30 2015  
MA Dept. of Public Health  
99 Chauncy Street  
Boston, MA 02111





**SECTION A. APPLICANT INFORMATION**

1. Health Circle, Inc.  
Legal name of Corporation
2. Michael Westort  
Name of Corporation's Chief Executive Officer
3. 25 Recreation Park Drive - #108  
Hingham, MA 02043  
Address of Corporation (Street, City/Town, Zip Code)
4. Michael Westort  
Applicant point of contact (name of person the Department should contact regarding this application)
5. 917-428-8461  
Applicant point of contact's telephone number
6. mkwestort@gmail.com  
Applicant point of contact's e-mail address
7. Number of applications: How many *Applications of Intent* do you intend to submit? 2

**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: AKW

Application 2 of 2 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
Julia Karis	Fidelity	Investment	\$300,000.00	
Julia Karis	Fidelity	Investment	\$13,000.00	
Lea Westort	Fidelity	Retirement Savings Account	\$87,000.00	
-----	-----	<b>TOTAL:</b>	\$400,000.00	----

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: 



**Publicis Benefits Connection  
401(k) Plan**

LEA WESTORT

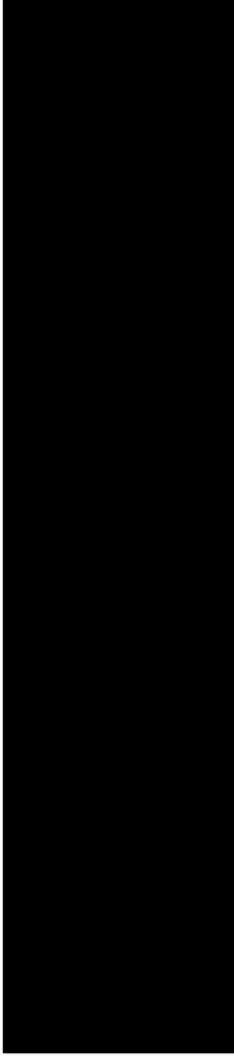


**Retirement Savings Statement**

Customer Service: (800) 835-5095  
Fidelity Investments Institutional Operations  
Company, Inc.  
82 Devonshire Street  
Boston, MA 02109

**Your Account Summary**

Statement Period: 06/01/2015 to 09/01/2015



**Ending Balance**

**\$319,031.95**



Your Personal Rate of Return is calculated with a time-weighted formula, widely used by financial analysts to calculate investment earnings. It reflects the results of your investment selections as well as any activity in the plan account(s) shown. There are other Personal Rate of Return formulas used that may yield different results. Remember that past performance is no guarantee of future results.



# The Colony Group

Two Atlantic Avenue  
Boston, Massachusetts 02110  
617.723.8200 Office  
617.723.6338 Fax  
[www.thecolonygroup.com](http://www.thecolonygroup.com)

September 29, 2015

Julia Karis  
166 Black Rock Drive  
Hingham, MA 02043

Dear Julie,

Per your request, please be advised that you have the following investment accounts under our management with values as of 9/28/2015:

- Fidelity Investments [REDACTED] \$320,986
- Fidelity Investments [REDACTED] \$13,900

If you have any questions, please do not hesitate to call me at 617-896-2180.

Sincerely,

THE COLONY GROUP, LLC



Erin Manganello, CFP®

Application 2 of 2 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.



9/30/15  
Date Signed

Signature of Authorized Signatory

Michael Westort

Print Name of Authorized Signatory

Chief Executive Officer, Health Circle, 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.



9/30/15  
Date Signed

Signature of Authorized Signatory

Michael Westort

Print Name of Authorized Signatory

Chief Executive Officer, Health Circle, 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.



9/30/15  
Date Signed

Signature of Authorized Signatory

Michael Westort

Print Name of Authorized Signatory

Chief Executive Officer, Health Circle, 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: 



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

William Francis Galvin  
Secretary of the  
Commonwealth

Date: September 29, 2015

To Whom It May Concern :

I hereby certify that

**HEALTH CIRCLE, INC.**

appears by the records of this office to have been incorporated under the General Laws of this  
Commonwealth on **June 24, 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: 15095502630

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

Processed by: nmc