EXHIBIT A

Account Agreement

Date: 03/25/20

Institution Name & Address

CHAIN BRIDGE BANK, N.A.
MCLEAN BRANCH
1445-A LAUGHLIN AVE
MCLEAN, VA 22101
(703) 748-2005

Internal Use: Easy Business Ck

Account Title & Address

Blue Flame Medical LLC
499 S Capitol St, SW, Ste 420
Washington DC 20003

Owner/Signer Information 1

Name	Michael C Gula
Relationship	Signer
Address	6128 Edgewood Terrace Alexandria VA 22307-0000
Mailing Address (if different)	6128 Edgewood Terrace Alexandria VA 22307
Gov't Issued Photo ID (type, number, state, issue date, exp. date)	Driver's License DL [redacted]8528 VA-03/27/17-[redacted]/25
Other ID (description, details)	
Employer	
Previous Financial Inst.	
E-Mail	mike@gulagraham.com
Work Phone	(202) 255-9745
Home Phone: (202) 255-9745	Mobile Phone: (202) 255-9745
Birth Date: [redacted]/80	SSN/TIN: [redacted]-2662

Ownership of Account

The specified ownership will remain the same for all accounts.

- ☐ Individual
- ☐ Joint with Survivorship (not as tenants in common) { X _____
- ☐ Joint with No Survivorship (as tenants in common) { X _____

- ☐ Sole Proprietorship or Single Member LLC ☐ Partnership
- ☒ LLC-enter tax classification (☐ C Corp ☒ S Corp ☐ Partnership)
- ☐ C Corporation ☐ S Corporation ☐ _____
- ☐ Trust-Separate Agreement Dated: _____
- ☐ _____

Beneficiary Designation

(Check appropriate ownership above.)

- ☐ Revocable Trust ☐ Pay-On-Death (POD)
- ☐ _____

Beneficiary Name(s), Address(es), and SSN(s)

(Check appropriate beneficiary designation above.)

Enter **Non-Individual Owner Information** on page 2. There is additional **Owner/Signer Information** space on page 2.

☐ If checked, this is a temporary account agreement.

Number of signatures required for withdrawal: 1 .

Signature(s)

The undersigned authorize the financial institution to investigate credit and employment history and obtain reports from consumer reporting agency(ies) on them as individuals. Except as otherwise provided by law or other documents, each of the undersigned is authorized to make withdrawals from the account(s), provided the required number of signatures indicated above is satisfied. The undersigned personally and as, or on behalf of, the account owner(s) agree to the terms of, and acknowledge receipt of copy(ies) of, this document and the following:

- ☒ Terms & Conditions ☒ Truth in Savings ☒ Funds Availability
- ☒ Electronic Fund Transfers ☒ Privacy ☒ Substitute Checks
- ☒ Common Features ☐ _____

☐ Authorized Signer (See Owner/Signer Information for Authorized Signer Designation(s).)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

(1): [X Michael C Gula]
I.D. # _____ D.O.B. _____

(2): [X John S. Thomas]
I.D. # _____ D.O.B. _____

(3): [X]
I.D. # _____ D.O.B. _____

(4): [X]
I.D. # _____ D.O.B. _____

Owner/Signer Information 2

Name	John S. Thomas
Relationship	Signer
Address	1415 Edgehill PL Pasadena CA 91103-0000
Mailing Address (if different)	1415 Edgehill PL Pasadena CA 91103
Gov't Issued Photo ID (type, number, state, issue date, exp. date)	Driver's License DL [redacted]2968 CA-08/15/19-[redacted]/24
Other ID (description, details)	
Employer	
Previous Financial Inst.	
E-Mail	john@blueflame.agency
Work Phone	
Home Phone:	Mobile Phone:
Birth Date: [redacted]/85	SSN/TIN: [redacted]-2005

Owner/Signer Information 3

Name	
Relationship	
Address	
Mailing Address (if different)	
Gov't Issued Photo ID (type, number, state, issue date, exp. date)	- -
Other ID (description, details)	
Employer	
Previous Financial Inst.	
E-Mail	
Work Phone	
Home Phone:	Mobile Phone:
Birth Date:	SSN/TIN:

Owner/Signer Information 4

Name	
Relationship	
Address	
Mailing Address (if different)	
Gov't Issued Photo ID (type, number, state, issue date, exp. date)	
Other ID (description, details)	
Employer	
Previous Financial Inst.	
E-Mail	
Work Phone	
Home Phone:	Mobile Phone:
Birth Date:	SSN/TIN:

Important Account Opening Information. Federal law requires us to obtain sufficient information to verify your identity. You may be asked several questions and to provide one or more forms of identification to fulfill this requirement. In some instances we may use outside sources to confirm the information. The information you provide is protected by our privacy policy and federal law.

Non-Individual Owner Information

Name	Blue Flame Medical LLC
State/Country & Date of Organization	DE 03/23/2020
Nature of Business	Medical consulting
Address	499 S Capitol St, SW, Ste 420 Washington DC 20003-0000
Mailing Address (if different)	499 S Capitol St, SW, Ste 420 Washington DC 20003
Authorization/ Resolution Date	
Previous Financial Inst.	
E-Mail	mike@gulagraham.com
Phone	(202) 255-9745
EIN: [redacted]5199	Mobile Phone:

Account Description	Account #	Initial Deposit/Source
Checking	[redacted]7459	$ ☐ Cash ☐ Check ☐
		$ ☐ Cash ☐ Check ☐
		$ ☐ Cash ☐ Check ☐

Services Requested

☐ ATM ☐ Debit/Check Cards (No. Requested: _____)
☐ _____ ☐ _____
☐ _____ ☐ _____

Backup Withholding Certifications

(If not a "U.S. Person", certify foreign status separately)

☒ By signing signature field (1) on this document, I certify under penalties of perjury that the statements made in this section are true and that I am a U.S. citizen or other U.S. person (as defined in the instructions).

☒ **Taxpayer I.D. Number - TIN:** [redacted]5199
The Taxpayer Identification Number (TIN) shown is my correct taxpayer identification number.

☒ **Backup Withholding.** I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

☐ **Exempt Recipients.** I am an exempt recipient under the Internal Revenue Service Regulations. Exempt payee code (if any) _____

FATCA Code. The FATCA code entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Other Terms/Information