

**Statement of Organization
Recipient Committee**

Statement Type

<input type="checkbox"/> Initial	<input checked="" type="checkbox"/> Amendment	<input type="checkbox"/> Termination – See Part 5
<input type="checkbox"/> Not yet qualified or <input type="checkbox"/> Date qualification threshold met	Date qualification threshold met 07 / 30 / 2024	Date of termination

RECEIVED

AUG 27 2024

CITY OF HEALDSBURG

**CALIFORNIA
FORM 410**

For Official Use Only

1. Committee Information		2. Treasurer and Other Principal Officers			
I.D. Number (if applicable) 1472097		NAME OF TREASURER SHAUN MCCAFFERY			
NAME OF COMMITTEE YES ON HEALDSBURG MEASURE O 2024		STREET ADDRESS (NO P.O. BOX)		CITY HEALDSBURG	STATE CA
STREET ADDRESS (NO P.O. BOX)		EMAIL ADDRESS OF TREASURER (REQUIRED)		ZIP CODE 95448	
CITY HEALDSBURG		NAME OF ASSISTANT TREASURER, IF ANY ALEX WOOD		AREA CODE/PHONE	
STATE CA		STREET ADDRESS (NO P.O. BOX)		CITY HEALDSBURG	STATE CA
ZIP CODE 95448		EMAIL ADDRESS OF ASSISTANT TREASURER (REQUIRED)		ZIP CODE 95448	
AREA CODE/PHONE		NAME OF PRINCIPAL OFFICER(S) SHAUN MCCAFFERY		AREA CODE/PHONE	
FULL MAILING ADDRESS (IF DIFFERENT)		STREET ADDRESS (NO P.O. BOX)		CITY HEALDSBURG	STATE CA
E-MAIL ADDRESS OF COMMITTEE (REQUIRED) / FAX (OPTIONAL)		EMAIL ADDRESS OF PRINCIPAL OFFICER(S) (REQUIRED)		ZIP CODE 95448	
COUNTY OF DOMICILE SONOMA	JURISDICTION WHERE COMMITTEE IS ACTIVE HEALDSBURG	NAME OF PRINCIPAL OFFICER(S) SHAUN MCCAFFERY		AREA CODE/PHONE	
Attach additional information on appropriately labeled continuation sheets.		STREET ADDRESS (NO P.O. BOX)		CITY HEALDSBURG	STATE CA
		EMAIL ADDRESS OF PRINCIPAL OFFICER(S) (REQUIRED)		ZIP CODE 95448	

3. Verification

I have used all reasonable diligence in preparing this statement and to the best of my knowledge the information contained herein is true and complete. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 8/10/2024 By SHAUN MCCAFFERY
DATE SIGNATURE OF TREASURER OR ASSISTANT TREASURER

Executed on _____ By _____
DATE SIGNATURE OF CONTROLLING OFFICEHOLDER, CANDIDATE, OR STATE MEASURE PROPONENT

Executed on _____ By _____
DATE SIGNATURE OF CONTROLLING OFFICEHOLDER, CANDIDATE, OR STATE MEASURE PROPONENT

Executed on _____ By _____
DATE SIGNATURE OF CONTROLLING OFFICEHOLDER, CANDIDATE, OR STATE MEASURE PROPONENT

Digitally signed by SHAUN MCCAFFERY
Date: 2024.08.11 15:53:32 -07'00'

**Statement of Organization
Recipient Committee**

INSTRUCTIONS ON REVERSE

COMMITTEE NAME YES ON HEALDSBURG MEASURE O 2024	I.D. NUMBER 1472097
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• All committees must list the financial institution where the campaign bank account is located and the person(s) authorized to obtain bank records.

NAME OF FINANCIAL INSTITUTION AND PERSON(S) AUTHORIZED TO OBTAIN BANK RECORDS EXCHANGE BANK	AREA CODE/PHONE 707-433-0400	BANK ACCOUNT NUMBER [REDACTED]	
ADDRESS OF FINANCIAL INSTITUTION 1031 VINE ST	CITY HEALDSBURG	STATE CA	ZIP CODE 95448

4. Type of Committee Complete the applicable sections.

Controlled Committee

- List the name of each controlling officeholder, candidate, or state measure proponent. If candidate or officeholder controlled, also list the elective office sought or held, and district number, if any, and the year of the election.
- List the political party with which each officeholder or candidate is affiliated or check "nonpartisan." Stating "No party preference" is acceptable.
- If this committee acts jointly with another controlled committee, list the name and identification number of the other controlled committee.

NAME OF CANDIDATE/OFFICEHOLDER/STATE MEASURE PROPONENT	ELECTIVE OFFICE SOUGHT OR HELD (INCLUDE DISTRICT NUMBER IF APPLICABLE)	YEAR OF ELECTION	PARTY CHECK ONE		(list political party below)
			Nonpartisan	Partisan	

Primarily Formed Committee

Primarily formed to support or oppose specific candidates or measures in a single election. List below:

CANDIDATE(S) NAME OR MEASURE(S) FULL TITLE (INCLUDE BALLOT NO. OR LETTER) IF A RECALL, STATE "RECALL" IN FRONT OF THE OFFICEHOLDER'S NAME.	CANDIDATE(S) OFFICE SOUGHT OR HELD OR MEASURE(S) JURISDICTION (INCLUDE DISTRICT NO., CITY OR COUNTY, AS APPLICABLE)	CHECK ONE	
		SUPPORT	OPPOSE
MEASURE O	HEALDSBURG	<input checked="" type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>