

00043

**APPLICATION FOR MEDICAL MARIJUANA CULTIVATION FACILITY  
SECTION A. GENERAL INFORMATION**

1. Name of Applicant (Must be a natural person.) [REDACTED]

2. Business Name TruCanna Farms, LLC

Fictitious Trade Name (if any) None

Business Mailing Address [REDACTED]

Texarkana, Arkansas 71854

Business telephone number 318-393-0352

3. Business entity type Limited Liability Company

Date of business formation or incorporation August 21, 2017

State(s) of Incorporation Arkansas

Registered Agent Name Charles Howard Bolton, Jr.

Registered Agent Address 2098 Miller County Road 53

Texarkana, Arkansas 71854

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed cultivation facility. Identify the nature of the individual's or corporation's affiliation with the proposed cultivation facility and the percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed cultivation facility is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4")

Section A. Number 4

[REDACTED] 51% Ownership of TruCanna Farms, LLC. [REDACTED]  
[REDACTED]

[REDACTED] 17% Ownership of TruCanna Farms, LLC. [REDACTED]  
[REDACTED]

[REDACTED] 16% Ownership of TruCanna Farms, LLC. [REDACTED]  
[REDACTED]

[REDACTED] 16% Ownership of  
TruCanna Farms. [REDACTED]  
[REDACTED]

5. **County of Proposed Location** Miller and Little River Counties
6. **City of Proposed Location (If inside city limits)** Texarkana (outside city limits)
7. **Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a cultivation facility license, under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.**

No additional application made.

8. **Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicant(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.**



# Section A Number 4

## Certification

I, [REDACTED], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

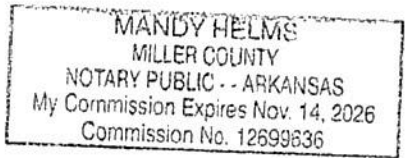
Signed this 1<sup>st</sup> day of SEPTEMBER, 2017.

[REDACTED]  
Signature of Applicant, Owner, Officer, or Board Member

Subscribed and sworn to before me this 1<sup>st</sup> day of September, 2017.

Mandy Helms  
Notary Public

My Commission Expires: November 14, 2026



APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person) [Redacted]

2. Business Name Empathic Therapeutics of Arkansas

Fictitious Trade Name (if any) [Redacted]

Business Mailing Address Morrilton AR 72110

Business telephone number 501-354-0420

3. Business entity type Incorporation

Date of business formation or incorporation 12-16-2016

State(s) of Incorporation Arkansas

Registered Agent Name Scott Hall

Registered Agent Address 75 N. East Ave Ste. 402  
Fayetteville AR 72701

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

See Attachment "Section A. Number 4"

5. County of Proposed Location Conway County

6. City of Proposed Location (If inside city limits) n/A

**"Section A. Number 4."  
Dispensary Application**

	Last Name	First Name	Affiliation with Dispensary	Total %	
			Board Member President, Stockholder	12.50%	
			Board Member Treasurer, Stockholder	12.50%	
			Board Member Secretary, Stockholder	12.50%	
			Board Member, Stockholder	10.00%	
			Board Member, Stockholder	10.50%	
			Board Member, Stockholder	10.50%	
			Board Member, Stockholder	10.00%	
			Stockholder	0.50%	
			Stockholder	0.50%	
			Stockholder	0.50%	
			Stockholder	0.50%	
			Stockholder	1.00%	
			Stockholder	1.00%	
			Stockholder	1.50%	
			Stockholder	2.00%	
			Stockholder	5.00%	
			Stockholder	8.00%	
				<b>99.00%</b>	

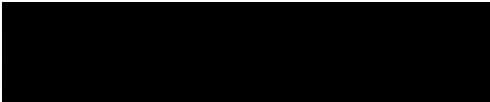
**1.00% of Ownership is being held by the corporation as treasury stock.**

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

no

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

Please see Attachment "Section A Number 8."



Certification

I, \_\_\_\_\_, certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 12<sup>th</sup> day of August, 2017.



Subscribed and sworn to before me this 12<sup>th</sup> day of August, 2017.

Julia A. Sommers

My Commission Expires: 4-23-2023







00057

**APPLICATION FOR MEDICAL MARIJUANA CULTIVATION FACILITY**

**SECTION A. GENERAL INFORMATION**

1. Name of Applicant (Must be a natural person.)

\_\_\_\_\_

2. Business Name HDMM Enterprises, LLC

Fictitious Trade Name (if any) Arkannabis Farms

Business Mailing Address \_\_\_\_\_

Hot Springs, AR 71913

Business telephone number 501-701-0102 or 501-463-1889

3. Business entity type LLC

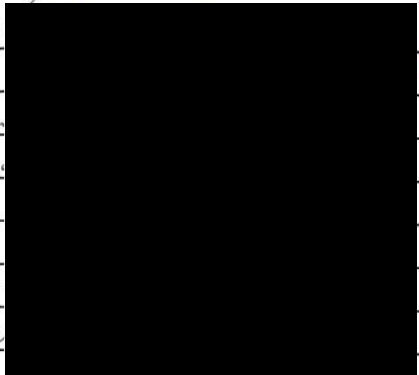
Date of business formation or incorporation June 16, 2017

State(s) of Incorporation ARKANSAS

Registered Agent Name John B. Dozier

Registered Agent Address 237 Wilson Point, Hot Springs, AR 71913

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed cultivation facility. Identify the nature of the individual's or corporation's affiliation with the proposed cultivation facility and the percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed cultivation facility is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

	24.5%	member
	24.5%	member
	12.25%	member
	12.25%	member
	12.25%	member
	12.25%	member
	1.00%	member
	1.00%	member

5. County of Proposed Location Hot Spring

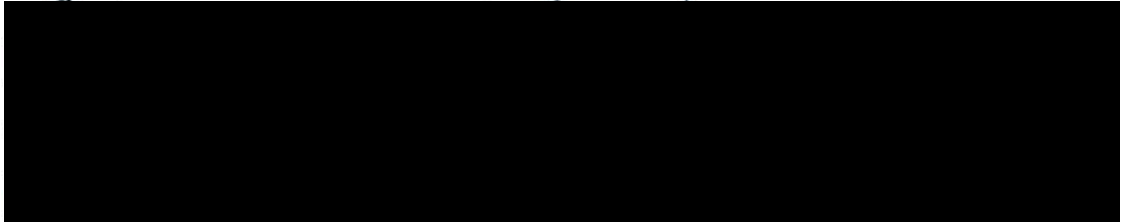
6. City of Proposed Location (If inside city limits) N/A

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a cultivation facility license, under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

No

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicant(s) for

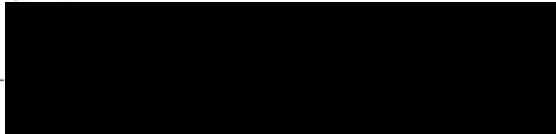
dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.



ification

I, \_\_\_\_\_, certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 13<sup>th</sup> day of July, 2017.



Subscribed and sworn to before me this 13<sup>th</sup> day of July, 2017.

Shelly C. Hill  
Notary Public

My Commission Expires: Dec 1, 2024



00062

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person)



2. Business Name Doctors Orders of Garland County, LLC

Fictitious Trade Name (if any) \_\_\_\_\_

Business Mailing Address Hot Springs, AR 71913

Business telephone number 501-701-0102 or 501-463-1889

3. Business entity type LLC

Date of business formation or incorporation 08/14/2017

State(s) of Incorporation Arkansas

Registered Agent Name Susan M. Dozier

Registered Agent Address 237 Wilson Point, Hot Springs, AR 71913

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

	member	38%
	member	11%
	member	24.5%
	member	24.5%
	member	1%
	member	1%

5. County of Proposed Location Garland

6. City of Proposed Location (If inside city limits) N/A

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

NO

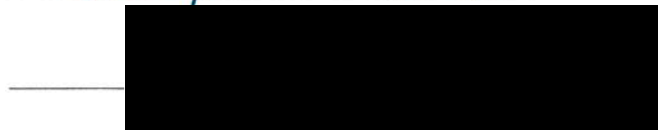
8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.



Certification

I, [Redacted], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 13<sup>th</sup> day of July, 2017.



Subscribed and sworn to before me this 13<sup>th</sup> day of July, 2017.

[Signature] Notary Public

My Commission Expires: Dec. 1, 2024



**APPLICATION FOR MEDICAL MARIJUANA CULTIVATION FACILITY**

**SECTION A. GENERAL INFORMATION**

1. **Name of Applicant** (Must be a natural person.)

[REDACTED]

2. **Business Name** River Valley Production, LLC

**Fictitious Trade Name (if any)** River Valley Relief Cultivation

**Business Mailing Address** [REDACTED] Fort Smith, AR 72916

**Business telephone number** 479-649-6909

3. **Business entity type** Limited Liability Company

**Date of business formation or incorporation** July 26th, 2017

**State(s) of Incorporation** Arkansas

**Registered Agent Name** John D Alford


**Registered Agent Address** 6804 Rogers Avenue, Suite B, Fort Smith, AR 72903



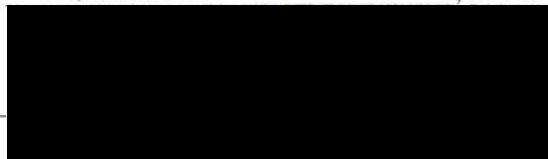
dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.



Certification

I, , certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

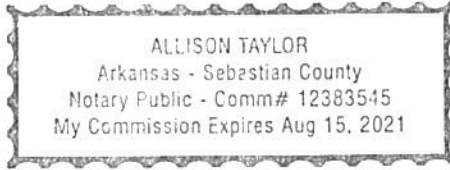
Signed this 11th day of September, 2017.



Subscribed and sworn to before me this 11th day of September, 2017.

Allison Taylor  
Notary Public

My Commission Expires: 8-15-2021





00073

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name The Willow Leaf, LLC

Fictitious Trade Name (if any) N/A

Business Mailing Address [Redacted] Fayetteville, AR 72701

Business telephone number (479) 331-3265

3. Business entity type Limited Liability Company

Date of business formation or incorporation June 22, 2017

State(s) of Incorporation Arkansas

Registered Agent Name Robert Kin Campbell

Registered Agent Address 201 N. Phoenix Avenue, Russellville, AR 72801

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

[Redacted] - 51% Ownership

[Redacted] - 24.50% Ownership

[Redacted] - 24.50% Ownership

5. County of Proposed Location Benton County

6. City of Proposed Location (If inside city limits) Lowell

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

No

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

No

Certification

I, [REDACTED], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this Eleventh day of September, 2017.

[REDACTED SIGNATURE]

Subscribed and sworn to before me this 11<sup>th</sup> day of September, 2017.

Patricia A. Bailey  
Notary Public

My Commission Expires: Nov 2, 2026



00080

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name M.M. DISPENSARY, INC.

Fictitious Trade Name (if any) N/A

Business Mailing Address [Redacted]

HOT SPRINGS, AR 71913

Business telephone number 501-247-3903

3. Business entity type CORPORATION-

Date of business formation or incorporation 30 AUG 2017

State(s) of Incorporation ARKANSAS

Registered Agent Name ANH Q. PHAM

Registered Agent Address 359 PALOS VERDES DR.  
HOT SPRINGS, AR 71913

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

- [Redacted] - 60% SHARE HOLDER
- [Redacted] - 15% SHARE HOLDER
- [Redacted] - 15% SHARE HOLDER
- [Redacted] - 5% SHARE HOLDER
- [Redacted] - 5% SHARE HOLDER

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5. County of Proposed Location GARLAND

6. City of Proposed Location (If inside city limits) HOT SPRINGS

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

NO

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

NO

Certification

I, [REDACTED], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 27th day of September, 2017.

[REDACTED]

Subscribed and sworn to before me this 27th day of September, 2017.

[Signature]

Notary Public

My Commission Expires \_\_\_\_\_



00082

APPLICATION FOR MEDICAL MARIJUANA CULTIVATION FACILITY


SECTION A. GENERAL INFORMATION

zone 4

1. Name of Applicant 

2. Business Name Agriculturist Association of Arkansas

Fictitious Trade Name (if any) Sisters of Empathy

Business Mailing Address   
Morrilton, AR 72110

Business telephone number (501) 354-0420

3. Business entity type Corp for Profit

Date of business formation or incorporation 12/2/16

State(s) of Incorporation Arkansas

Registered Agent Name Scott Hall

Registered Agent Address 75 N. East Ave, Ste 402  
Fayetteville, AR 72701



dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

Please see the attachment "Section A. Number 8"

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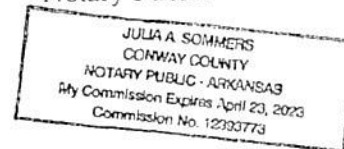
I, [REDACTED] certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 8<sup>th</sup> day of August, 2017.

Subscribed and sworn to before me this 8<sup>th</sup> day of August 2017.

Julia A. Sommers  
Notary Public

My Commission Expires: 4-23-2023



**APPLICATION FOR MEDICAL MARIJUANA CULTIVATION FACILITY**  
**SECTION B. Applicant, Owner, Officer, or Board Member Disclosure Statement**

Identify your affiliation with the proposed cultivation facility (Applicant, Owner, Officer, Board Member?) Include your percentage of equity ownership in the facility, if any.

Affiliation: APPLICANT

Percentage of Equity Ownership: 60%

**Legal Name**

\*In addition to the information below, you are required to provide supporting documents to prove your legal name. See Section B, Appendix 1 for acceptable forms of proof.

Last Name [REDACTED]

First Name [REDACTED]

Middle Name [REDACTED]

Maiden Name (if applicable) [REDACTED]

Alias(es) or former names N/A

SSN [REDACTED]

**Date of Birth**

\*In addition to providing your date of birth, you are required to provide supporting documents to prove your date of birth. See Section B, Appendix 2 for acceptable forms of proof.

Date of Birth [REDACTED]

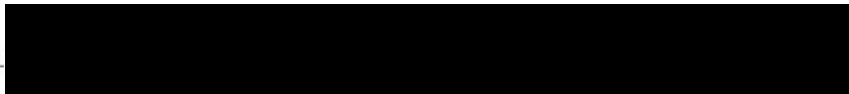
**Contact Information**

Mailing Address [REDACTED]

Phone Number (primary contact number) [REDACTED]



Email Address \_\_\_\_\_



**Residency**

Are you an Arkansas resident? \_\_\_\_\_

YES

If you are not an Arkansas resident, please identify your primary place of residence.

N/A

Have you been an Arkansas resident for the past seven (7) years? \_\_\_\_\_

YES

If you answered "yes" to the question above, in addition to providing the information requested below, you are required to provide supporting documents to prove your residency for the past seven (7) years. See Section B, Appendix 3 for acceptable forms of proof.

Provide the address of your primary residence(s) for the past seven (7) years. Identify the dates (month and year) you resided at each listed location:



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tax Liability**

Do you have any outstanding tax delinquencies owed to the State of Arkansas: \_\_\_\_\_

NO

If you answered "yes" to the previous question, please explain the nature of any delinquencies:

N/A

\_\_\_\_\_  
\_\_\_\_\_

**Other Financial Liabilities**

Are you a party to any legal proceedings where damages, fines, or civil penalties may reasonably be expected to exceed \$500,000 above any insurance coverage available to cover the claim?

\_\_\_\_\_ NO \_\_\_\_\_

If the answer to the above question is "yes", attach a statement describing the litigation, including the title and docket number of the litigation, the name and location of the court in which it is pending, the identity of all parties to the litigation, the general nature of the claims being made and the impact an unfavorable opinion may have on your ability to finance and operate the proposed cultivation facility. Any documents submitted in response to this requirement must be labeled with "Section B, Other Financial Liabilities".

**Regulatory History**

Have you, or has any entity over which you exercised management or control, ever had any fines or other penalties over \$10,000 assessed by any regulatory agency? \_\_\_\_\_ NO \_\_\_\_\_

If the answer above is "yes", attach a statement providing the details of such fines or penalties. Any documents submitted in response to this requirement must be labeled with "Section B, Regulatory History".

**Professional Licensure**

Do you presently hold any type of professional license? \_\_\_\_\_ NO \_\_\_\_\_

If yes, identify the type of license and license number \_\_\_\_\_

Is the license in good standing? \_\_\_\_\_

Certification

I, [REDACTED], certify that the information provided in this form is accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 4<sup>th</sup> day of August, 2017.

[REDACTED]  
\_\_\_\_\_  
Signature of Applicant, Owner, Officer, or Board Member

Subscribed and sworn to before me this 4<sup>th</sup> day of August, 2017.

Mary Heads  
\_\_\_\_\_  
Notary Public

My Commission Expires: 04-24-24

MARY HEADS  
Carroll County - Arkansas  
Notary Public #12398646  
My Commission Expires April 24, 2024

00091

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name NSK Medical Exchange, LLC.

Fictitious Trade Name (if any) Natural State of Kind

Business Mailing Address [Redacted] Little Rock, AR 72201

Business telephone number 501-408-2420

3. Business entity type LLC

Date of business formation or incorporation August 7, 2017

State(s) of Incorporation AR

Registered Agent Name Jason Martin

Registered Agent Address 400 W. Capitol Ave., Suite 1700, Little Rock, AR 72201

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

[Redacted]	- Owner Applicant - 51%
[Redacted]	Owner - 5%
[Redacted]	Owner - 14.5%
[Redacted]	- Owner - 5%
[Redacted]	Owner - 14.5%
[Redacted]	- Board Member - 0%
[Redacted]	- Owner - 5%
[Redacted]	- Board Member - 0%
[Redacted]	- Owner - 5%
[Redacted]	- Board Member - 0%
[Redacted]	- Board Member - 0%
[Redacted]	- Board Member - 0%

5. County of Proposed Location Location 1 - Saline, Location 2 - Garland

6. City of Proposed Location (If inside city limits) Location 1 - Bryant, Location 2 - Hot Springs

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

[Redacted]

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

[Redacted]

Certification

I, [Redacted], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

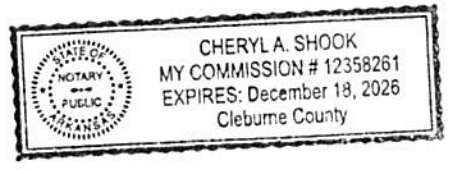
Signed this 9<sup>th</sup> day of August, 2017.

[Redacted Signature]

Subscribed and sworn to before me this 9 day of August, 2017.

C Cheryl A. Shook  
Notary Public

My Commission Expires: 12-18-2026



00105

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted Name]

2. Business Name Arkansas Natural Remedies, LLC

Fictitious Trade Name (if any) \_\_\_\_\_

Business Mailing Address [Redacted]

Little Rock, AR 72201

Business telephone number 501-372-1722

3. Business entity type LLC

Date of business formation or incorporation MAY 4, 2017

State(s) of Incorporation ARKANSAS

Registered Agent Name William Ables

Registered Agent Address 111 Center Street, Suite 1200,  
Little Rock, AR 72201

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

- [Redacted] Owner 67%
- [Redacted] Owner, General Manager 10%
- [Redacted] Owner, 10%
- [Redacted] Owner, 10%
- [Redacted] 10%

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5. County of Proposed Location PRAIRIE

6. City of Proposed Location (If inside city limits) HAZEN, AR

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ABC  
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7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

No

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

No

Certification

I, [REDACTED], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 28 day of August, 2017.

[REDACTED]

Subscribed and sworn to before me this 28 day of August, 2017.

Matilda Buchanan

Notary Public

My Commission Expires: 1/10/2025



00119

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name Valentine Holdings, LLC

Fictitious Trade Name (if any)

Business Mailing Address

[Redacted]

Jonesboro, AR 72403

Business telephone number 870-268-7601

3. Business entity type Limited Liability Company

Date of business formation or incorporation April 6, 2017

State(s) of Incorporation Arkansas

Registered Agent Name Donald L. Parker II

Registered Agent Address 3000 Browns Lane, Jonesboro, AR 72401

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

[Redacted] -owner - 32.3334%  
[Redacted] -owner - 1%  
[Redacted] -owner - 32.3333%  
[Redacted] -owner - 1%  
[Redacted] -owner - 33.3333%

5. County of Proposed Location Sebastian County

6. City of Proposed Location (If inside city limits) Fort Smith



7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

[Redacted]

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

[Redacted]

Certification

I, [Redacted], certify that the information provided in this form is accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 12<sup>th</sup> day of September, 2017.

[Redacted Signature]

Subscribed and sworn to before me this 12<sup>th</sup> day of September, 2017.

Natasha Wheeler

Notary Public

My Commission Expires: 11-17-2026

NATASHA WHEELER  
NOTARY PUBLIC-STATE OF ARKANSAS  
RANDOLPH COUNTY  
My Commission Expires 11-17-2026  
Commission # 12699195

00143

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name Grassroots OpCo AR, LLC

Fictitious Trade Name (if any) Grassroots Cannabis

Business Mailing Address [Redacted] Chicago, Illinois 60602

Proposed Facility Address: 4423 East Broad Street, Texarkana, Arkansas 71854

Business telephone number 773-870-2439

3. Business entity type Limited Liability Company

Date of business formation or incorporation August 17, 2017

State(s) of Incorporation Arkansas

Registered Agent Name Corporation Services Company

300 South Spring Street, Spring Building, Suite 900

Registered Agent Address Little Rock, Arkansas 72201

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

[Redacted]	(Applicant Owner)	70.200%
[Redacted]	(Owner)	20.100%
[Redacted]	(Owner)	0.050%
[Redacted]	LLC	4.075%
[Redacted]		4.075%
[Redacted]		1.500%
	TOTAL	100.000%

5. County of Proposed Location Miller County

6. City of Proposed Location (If inside city limits) Texarkana

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

[Redacted]

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

[Redacted]

Certification

I, [Redacted], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this 11 day of September, 2017.

[Redacted Signature]

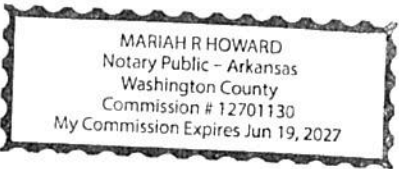
Signature of Applicant

Subscribed and sworn to before me this 11th day of September, 2017.

[Handwritten Signature]

Notary Public

My Commission Expires: 06/19/2027



APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

\_\_\_\_\_

2. Business Name THE HEALTH CENTER

Fictitious Trade Name (if any) \_\_\_\_\_

Business Mailing Address \_\_\_\_\_ CONWAY, AR 72033

Business telephone number 501-733-6628

3. Business entity type LIMITED LIABILITY COMPANY

Date of business formation or incorporation APRIL 25, 2017

State(s) of Incorporation ARKANSAS

Registered Agent Name DANIEL GOODWIN

Registered Agent Address 425 W. CAPITOL AVE. SUITE 3800 LITTLE ROCK, AR 72201

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

\_\_\_\_\_ SHAREHOLDER/MANAGING PARTNER 22%

\_\_\_\_\_ SHAREHOLDER/MANAGING PARTNER 22%

\_\_\_\_\_ SHAREHOLDER 5%

\_\_\_\_\_ SHAREHOLDERS 51%

\_\_\_\_\_ 25.6%

\_\_\_\_\_ 25.6%

5. County of Proposed Location FAULKNER

6. City of Proposed Location (If inside city limits) CONWAY



7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

NO. N/A

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

NO. N/A

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Certification

I, [REDACTED], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

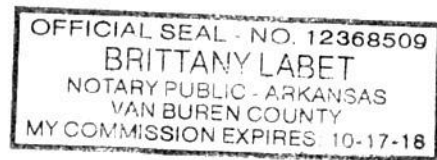
Signed this 16<sup>th</sup> day of September, 2017.

[REDACTED]

Subscribed and sworn to before me this 16<sup>th</sup> day of September, 2017.

Brittany Labet  
Notary Public

My Commission Expires: 10-17-18



00172

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name The Comfort Clinic, LLC

Fictitious Trade Name (if any) N/A

Business Mailing Address [Redacted] Fort Smith, Arkansas 72908

Business telephone number 479-739-0220

3. Business entity type Limited Liability Company

Date of business formation or incorporation 07/19/2017

State(s) of Incorporation Arkansas

Registered Agent Name Amanda Villines

Registered Agent Address 9708 Bramble Brae, Fort Smith, Arkansas 72908

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

The following individuals equally own the Applying Entity, The Comfort Clinic, LLC:

- [Redacted] owns 14.285% of the proposed dispensary.
- [Redacted] owns 14.285% of the proposed dispensary.
- [Redacted] owns 14.285% of the proposed dispensary.
- [Redacted] owns 14.285% of the proposed dispensary.
- [Redacted] owns 14.285% of the proposed dispensary.
- [Redacted] owns 14.285% of the proposed dispensary.
- [Redacted] owns 14.285% of the proposed dispensary.

Please see attached Articles of Organization and Operating Agreement for The Comfort Clinic, LLC

5. County of Proposed Location Johnson

6. City of Proposed Location (If inside city limits) Clarksville

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

No

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

No

Certification

[Redacted], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

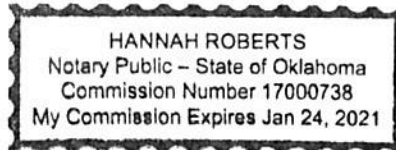
Signed this 6<sup>th</sup> day of September, 2017.

Subscribed and sworn to before me this 6 day of September, 2017.

Hannah Roberts

Notary Public

My Commission Expires: Jan 24, 2021



00174

**APPLICATION FOR MEDICAL MARIJUANA CULTIVATION FACILITY**

**SECTION A. GENERAL INFORMATION**

**1. Name of Applicant** (Must be a natural person.)

\_\_\_\_\_

**2. Business Name** The Comfort Clinic, LLC

**Fictitious Trade Name (if any)** N/A

**Business Mailing Address** \_\_\_\_\_ Fort Smith, Arkansas 72908

**Business telephone number** 479-739-0220

**3. Business entity type** Limited Liability Company

**Date of business formation or incorporation** 07/19/2017

**State(s) of Incorporation** Arkansas

**Registered Agent Name** Amanda Villines

**Registered Agent Address** 9708 Bramble Brae, Fort Smith, Arkansas 72908



4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed cultivation facility. Identify the nature of the individual's or corporation's affiliation with the proposed cultivation facility and the percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed cultivation facility is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

The following individuals equally own the Applying Entity, The Comfort Clinic, LLC:

- \_\_\_\_\_ owns 14.285% of the proposed cultivation facility
- \_\_\_\_\_ owns 14.285% of the proposed cultivation facility
- \_\_\_\_\_ owns 14.285% of the proposed cultivation facility
- \_\_\_\_\_ owns 14.285% of the proposed cultivation facility
- \_\_\_\_\_ owns 14.285% of the proposed cultivation facility
- \_\_\_\_\_ owns 14.285% of the proposed cultivation facility

Please see attached Articles of Organization and Operating Agreement for The Comfort Clinic, LLC.

5. County of Proposed Location Searcy

6. City of Proposed Location (If inside city limits) Marshall

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a cultivation facility license, under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

No

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicant(s) for

**dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.**

No

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I, [REDACTED], certify that the information provided in this form is true and correct. I understand that any misstatement or concealment may result in denial, suspension, application or revocation of license if later disclosed.

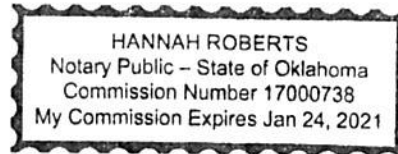
Signed this 6 day of September, 2017

[REDACTED]

Subscribed and sworn to before me this 6 day of September, 2017.

Hannah Roberts  
Notary Public

My Commission Expires: Jan 24 2021



00179

APPLICATION FOR MEDICAL MARIJUANA DISPENSARY

SECTION A. GENERAL INFORMATION

1. Name of Applicant (Must be a natural person.)

[Redacted]

2. Business Name Serene Green Wellness

Fictitious Trade Name (if any) \_\_\_\_\_

Business Mailing Address [Redacted] Little Rock AR 72223

Business telephone number (501) 519-2570

3. Business entity type LLC

Date of business formation or incorporation August 8th 2017

State(s) of Incorporation ARKANSAS

Registered Agent Name Kelli Dyanne Bennett

Registered Agent Address 615 Dalewood Benton AR 72015

4. List all owners, stockholders, shareholders, members, officers, and board members of the proposed dispensary. Identify the nature of the individual's or corporation's affiliation with the proposed dispensary and percentage of ownership, if any. NOTE: Please make sure that 100% of the ownership interest in the proposed dispensary is accounted for in this section. (Attach any necessary additional pages to this form. Include a header on any attachments. The header for this response should include "Section A. Number 4.")

- [Redacted] 34% CEO
- [Redacted] 31% Patient Research Manager
- [Redacted] 20% OPERATIVE MANAGERS
- [Redacted] 5% CULTIVATION PLANT PATHOLOGIST MANAGER
- [Redacted] 5% CULTIVATION PLANT PATHOLOGIST
- [Redacted] 5% BOARD MEMBER/LANDLORD

5. County of Proposed Location Saline county

6. City of Proposed Location (If inside city limits) BRYANT AR

7. Has the applicant or business entity filed, or does the applicant or business entity intend to file an additional application for a dispensary license under the same or a different name at a different location? If so, please provide the location(s) and any other name under which the application(s) will be made.

NO

8. Is the Applicant or any owner, stockholder, shareholder, officer, or board member in any way affiliated with any other applicants(s) for dispensaries/cultivation centers? If yes, please identify the individual and the name of the proposed cultivation facility or dispensary, and briefly describe the nature of the relationship.

NO

Certification

I, [REDACTED], certify that the information provided in this form and its attachments is complete and accurate. I understand that any misstatement or concealment of fact may be grounds for refusal of application or revocation of license if later disclosed.

Signed this

14<sup>th</sup>

day of Sept 2017  
[REDACTED]

Subscribed and sworn to before me this

14<sup>th</sup>

day of

Sept

2017

[Signature]

Notary Public

My

Mississippi Expires

12-15-25

