

LD6 000112720

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP     WAIT     MAIL

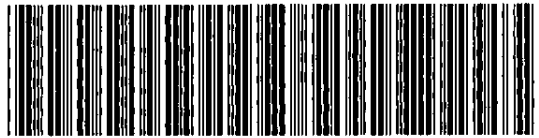
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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06/24/11--01016--018 \*\*25.00

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11 JUN 23 PM 12:57  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

D. BRUCE

JUN 24 2011

EXAMINER

NO \$



FLORIDA DEPARTMENT OF STATE  
Division of Corporations

June 13, 2011

JOSEPH DI CAPUA  
7800 WEST OAKLAND PARK BLVD., STE E-214  
SUNRISE, FL 33351

SUBJECT: PHYSICIANS HEALTH CARE SYSTEMS, LLC  
Ref. Number: L06000112720

We have received your document for PHYSICIANS HEALTH CARE SYSTEMS, LLC, however, upon receipt of your document no check was enclosed. Please return your **document** along with a **check** or **money order** made payable to the Department of State for \$25.00.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6984.

Deborah Bruce  
Regulatory Specialist II

Letter Number: 711A00014403

11 JUN 23 PM 12:57  
F.M. EID  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

**COVER LETTER**

**TO:** Registration Section  
Division of Corporations

**SUBJECT:** Physicians Health Care Systems, LLC  
Name of Limited Liability Company

The enclosed Articles of Amendment and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Joseph Di Capua  
Name of Person  
Physicians Health Care Systems, LLC  
Firm/Company  
7800 West Oakland Park Blvd., Suite E-214  
Address  
SUNRISE, FL 33351  
City/State and Zip Code  
LDiCapua@rmainc.org  
E-mail address: (to be used for future annual report notification)

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SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

For further information concerning this matter, please call:

Lucie Di Capua at ( 954 ) 318-6590 Ext. 103  
Name of Person Area Code & Daytime Telephone Number

Enclosed is a check for the following amount:

- \$25.00 Filing Fee
- \$30.00 Filing Fee & Certificate of Status
- \$55.00 Filing Fee & Certified Copy (additional copy is enclosed)
- \$60.00 Filing Fee, Certificate of Status & Certified Copy (additional copy is enclosed)

**MAILING ADDRESS:**  
Registration Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

**STREET/COURIER ADDRESS:**  
Registration Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

**ARTICLES OF AMENDMENT  
TO  
ARTICLES OF ORGANIZATION  
OF**

**Physicians Health Care Systems, LLC**

(Name of the Limited Liability Company as it now appears on our records.)  
(A Florida Limited Liability Company)

The Articles of Organization for this Limited Liability Company were filed on 11/21/2006 and assigned Florida document number L06000112720.

This amendment is submitted to amend the following:

**A. If amending name, enter the new name of the limited liability company here:**

Physicians Healthcare Systems, LLC

The new name must be distinguishable and end with the words "Limited Liability Company," the designation "LLC" or the abbreviation "L.L.C."

**Enter new principal offices address, if applicable:**

**(Principal office address MUST BE A STREET ADDRESS)**

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

**Enter new mailing address, if applicable:**

**(Mailing address MAY BE A POST OFFICE BOX)**

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

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TALLAHASSEE, FLORIDA

**B. If amending the registered agent and/or registered office address on our records, enter the name of the new registered agent and/or the new registered office address here:**

Name of New Registered Agent: \_\_\_\_\_

New Registered Office Address: \_\_\_\_\_

*Enter Florida street address*

\_\_\_\_\_, **Florida** \_\_\_\_\_

*City*

*Zip Code*

**New Registered Agent's Signature, if changing Registered Agent:**

*I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent as provided for in Chapter 608, F.S. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.*

\_\_\_\_\_  
**If Changing Registered Agent, Signature of New Registered Agent**

If amending the Managers or Managing Members on our records, enter the title, name, and address of each Manager or Managing Member being added or removed from our records:

MGR = Manager  
MGRM = Managing Member

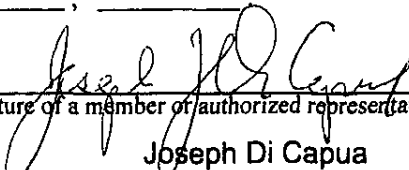
<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Remove
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_____	_____	_____	<input type="checkbox"/> Add <input type="checkbox"/> Remove

D. If amending any other information, enter change(s) here: *(Attach additional sheets, if necessary)*

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

STATE TARY OF ST. JAMES  
 TALLAHASSEE, FLORIDA  
 JUN 23 PM 12:57  
 F.M. END

Dated \_\_\_\_\_

  
 \_\_\_\_\_  
 Signature of a member or authorized representative of a member  
 Joseph Di Capua  
 \_\_\_\_\_  
 Typed or printed name of signee