

412000058908

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

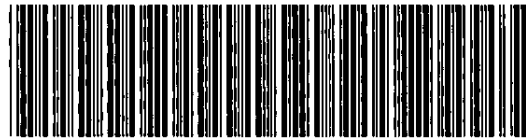
(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer:

Office Use Only



200235564572

05/29/12--01041--005 **25.00

12 MAY 29 PM 5:14
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

FILED

D. BRUCE
MAY 30 2012
EXAMINER

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: HOSPITAL ALLIANCE 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:

MEHMET AYDIN ATILLA, MD

Name of Person

HOSPITALIST ALLIANCE LLC

Firm/Company

3706 N ROOSEVELT BLVD, STE I

Address

KEY WEST, FL 33040

City/State and Zip Code

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

CHRISTIAN CASTRO

Name of Person

at (954)

739-9000

Area Code & Daytime Telephone Number

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

12 MAY 29 PM 5:16

FILED

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

HOSPITAL ALLIANCE, LLC

Page 1 of 2

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>
--------------	-------------	----------------	-----------------------

			☐ Add
			☐ Remove

			☐ Add
			☐ Remove

			☐ Add
			☐ Remove

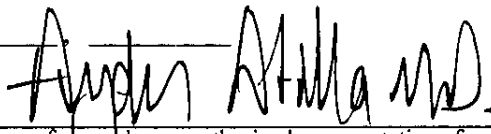
			☐ Add
			☐ Remove

			☐ Add
			☐ Remove

			☐ Add
			☐ Remove

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

Dated _____



Signature of a member or authorized representative of a member

MEHMET AYDIN ATILLA, MD

Typed or printed name of signee

12 MAY 29 PM 5:14
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

FILED