

L14000 187293

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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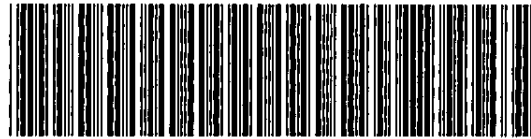
(Business Entity Name)

(Document Number)

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DEC 08 2014  
J. HARRIS

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT: Laser Spine Surgery Center of Tampa, LLC  
Name of Limited Liability Company**

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

Please return all correspondence concerning this matter to the following:

Kim A. Maurer  
Name of Person

Laser Spine Institute, LLC  
Firm/Company

3031 N. Rocky Point Drive W., Suite 300  
Address

Tampa, FL 33607  
City/State and Zip Code

kmaurer@laserspineinstitute.com  
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Kim A. Maurer at ( 813 ) 289-9613  
Name of Person Area Code Daytime Telephone Number

Enclosed is a check for the following amount:

- \$125.00 Filing Fee       \$130.00 Filing Fee & Certificate of Status       \$155.00 Filing Fee & Certified Copy (additional copy is enclosed)       \$160.00 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 ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY**

**ARTICLE I - Name:**

The name of the Limited Liability Company is:

Laser Spine Surgery Center of Tampa, LLC

(Must end with the words "Limited Liability Company, "L.L.C.," or "LLC.")

**ARTICLE II - Address:**

The mailing address and street address of the principal office of the Limited Liability Company is:

**Principal Office Address:**

**Mailing Address:**

5332 Avion Park Drive  
Tampa, FL 33607  
[Future address; under construction]

5332 Avion Park Drive  
Tampa, FL 33607  
[Present address]

**ARTICLE III - Registered Agent, Registered Office, & Registered Agent's Signature:**

(The Limited Liability Company cannot serve as its own Registered Agent. You must designate an individual or another business entity with an active Florida registration.)

The name and the Florida street address of the registered agent are:

CT Corporation System  
Name

1200 South Pine Island Road  
Florida street address (P.O. Box **NOT** acceptable)

Plantation                                      FL 33324  
City    Zip

*Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, 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 relating 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 605, F.S.*



\_\_\_\_\_  
Registered Agent's Signature (REQUIRED)

(CONTINUED)

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**ARTICLE IV-**

The name and address of each person authorized to manage and control the Limited Liability Company:

**Title:**

"AMBR" = Authorized Member

"MGR" = Manager

MGR

**Name and Address:**

Medical Care Management Services, LLC

3031 N. Rocky Point Drive W., Suite 300

Tampa, FL 33607

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Use attachment if necessary)


**ARTICLE V:** Effective date, if other than the date of filing: \_\_\_\_\_ (OPTIONAL)

(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**ARTICLE VI:** Other provisions, if any.

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

**REQUIRED SIGNATURE:**



**Signature of a member or an authorized representative of a member.**

(In accordance with section 605.0203 (1) (b), Florida Statutes, the execution of this document constitutes an affirmation under the penalties of perjury that the facts stated herein are true.

I am aware that any false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.)

Doty Bollinger, RN, JD, CASC, LHRM - President & COO

Typed or printed name of signee

**Medical Care Management Services, LLC**

**Filing Fees:**

**\$125.00 Filing Fee for Articles of Organization and Designation of Registered Agent**

**\$ 30.00 Certified Copy (Optional)**

**\$ 5.00 Certificate of Status (Optional)**

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