

600671

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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PICK-UP

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MAIL

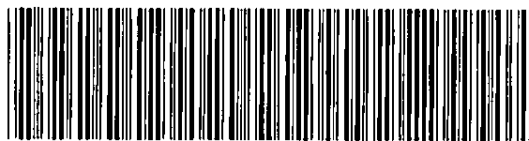
(Business Entity Name)

(Document Number)

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TALENT, MASSACHUSETTS

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COVER LETTER

TO: Amendment Section
Division of Corporations

SUBJECT: Oral and maxillofacial Surgeons of Mid-Florida, P.A.
Name of Corporation

DOCUMENT NUMBER: 600671

The enclosed Statement of Change of Registered Office/Agent and fee are submitted for filing.

Please return all correspondence concerning this matter to the following:

Pam Scott
Name of Contact Person

Oral + Facial Surgeons of Mid-Florida
Firm/Company

195 Briar Cliff Dr., Ste. 101
Address

Longwood, FL 32779
City/State and Zip Code

pscott@ofs.cc
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Pam Scott at (407) 774-3399
Name of Contact Person Area Code & Daytime Telephone Number

Enclosed is a \$35.00 check made payable to the Department of State.

Mailing Address:

Amendment Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Street Address:

Amendment Section
Division of Corporations
The Centre of Tallahassee
2415 N. Monroe Street, Suite 810
Tallahassee, FL 32303

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SECRETARY
TALLAHASSEE
FL

**STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT OR BOTH
FOR CORPORATIONS**

Pursuant to the provisions of sections 607.0502, 617.0502, 607.1508, or 617.1508, Florida Statutes, this statement of change is submitted for a corporation organized under the laws of the State of Florida in order to change its registered office or registered agent, or both, in the State of Florida.

1. The name of the corporation: Oral and Maxillofacial Surgeons of Mid-Florida, P.A.
2. The principal office address: 195 Briar Cliff Dr., Ste 101, Longwood, FL 32779

3. The mailing address (if different): _____

4. Date of incorporation/qualification: _____ Document number: 600671

5. The name and street address of the current registered agent and registered office on file with the Florida Department of State: (If resigned, enter resigned)

re signed

6. The name and street address of the new registered agent (if changed) and /or registered office (if changed):

Bobby C. Garfinkel, D.M.D.

195 Briar Cliff Dr., Ste. 101

P.O. Box NOT acceptable

Longwood, FL 32779

SECRETARY OF STATE
TALLAHASSEE, FL

2023 OCT 31 PM 5:00

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The street address of its registered office and the street address of the business office of its registered agent, as changed will be identical.

Such change was authorized by resolution duly adopted by its board of directors or by an officer so authorized by the board, or the corporation has been notified in writing of the change.

[Signature]
Signature of an officer or director

Bobby C. Garfinkel, D.M.D.
Printed or typed name and title

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 obligation of my position as registered agent. Or, if this document is being filed merely to reflect a change in the registered office address, I hereby confirm that the corporation has been notified in writing of this change.

[Signature]
Signature of Registered Agent

10/26/2023
Date

If signing on behalf of an entity:

Bobby C. Garfinkel, D.M.D.
Typed or Printed Name

*** FILING FEE: \$35.00 ***

MAKE CHECKS PAYABLE TO FLORIDA DEPARTMENT OF STATE
MAIL TO: DIVISION OF CORPORATIONS, P.O. BOX 6327, TALLAHASSEE, FL 32314
CR2E045 (04/13)