

A21000000079

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

(Business Entity Name)

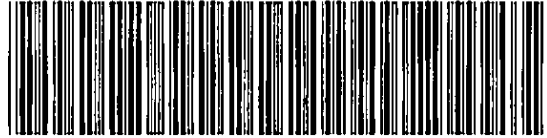
(Document Number)

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**COVER LETTER**

**TO:** Registration Section

Division of Corporations

**SUBJECT:** WHOLE CARE MEDICAL STAFFING SOLUTIONS LLC  
(Name of Florida Limited Partnership or Limited Liability Limited Partnership)

The enclosed Certificate of Dissolution and fee(s) are submitted for filing.  
Please return all correspondence concerning this matter to:

TRIFFINA BROWN  
(Contact Person)

WHOLE CARE MEDICAL STAFFING SOLUTIONS LLC  
(Firm/Company)

205 BELLA VERANO LANE  
(Address)

DAVENPORT 33597  
(City, State and Zip Code)

For further information concerning this matter, please call:

TRIFFINA BROWN at (954) 605 7971  
(Name of Contact Person) (Area Code) (Daytime Telephone Number)

Enclosed is a check for the following amount: Already enclosed previously

☐ \$52.50 Filing Fee

☐ \$61.25 Filing Fee  
and Certificate of  
Status

☐ \$105.00 Filing Fee  
and Certified Copy

☐ \$113.75 Filing Fee,  
Certified Copy, and  
Certificate of Status

**STREET ADDRESS:**

Registration Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

**MAILING ADDRESS:**

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

**CERTIFICATE OF DISSOLUTION  
FOR**

WHOLE CARE MEDICAL STAFFING SOLUTIONS LLC

(Name of Florida Limited Partnership or Limited Liability Limited Partnership)

Pursuant to the provisions of section 620.1203, Florida Statutes, this Florida limited partnership or limited liability limited partnership, whose certificate was filed with the Florida Department of State on 2/9/2021, assigned Florida document number A21000000079 hereby submits this Certificate of Dissolution.

**FIRST:** Reason for dissolution: (State why partnership is submitting dissolution)

NON FUNCTIONAL

**SECOND:** ☒ A Notice of Dissolution is attached.  
(Check box if attached.)

**THIRD:** Effective date, if other than the date of filing: 12/1/2021  
(Effective date cannot be prior to nor more than 90 days after the date this document is filed by the Florida Department of State.)

**Note:** If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as the document's effective date on the Department of State's records.

Signatures of each general partner or the person appointed pursuant to s. 620.1803(3) or (4), F.S.:

J. Brown  
CK [Signature]

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

Filing Fee: \$52.50  
Certified Copy (optional): \$52.50  
Certificate of Status (optional): \$8.75

**NOTICE OF DISSOLUTION  
FOR  
FLORIDA LIMITED PARTNERSHIP  
OR LIMITED LIABILITY LIMITED PARTNERSHIP**

This notice is submitted by the dissolved limited partnership or limited liability limited partnership named below or the successor entity for resolution of payment of unknown claims against this limited partnership or limited liability limited partnership as provided in s. 620.1807, F.S.

This "Notice of Dissolution" is optional and is not required when filing a Certificate of Dissolution.

Name of Dissolved Limited Partnership or Limited Liability Limited Partnership:

WholeCare Medical Staffing Solutions LLP

Description of information that must be included in a claim:

Temporary staffing agency.

Mailing address where claims can be sent: (Claims cannot be sent to the Florida Department of State.)

37 N Orange Ave Ste 328  
Orlando FL 32801

A claim against the above named limited partnership or limited liability limited partnership will be barred unless a proceeding to enforce the claim is commenced within 4 years after the filing of the notice.

Signature of a general partner or a principal of the successor entity:

Triffina Brown      J. Brown  
Printed Name      Signature

**Fee: No charge if included with Certificate of Dissolution. If filed separately, \$52.50.**