

U04000045654

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

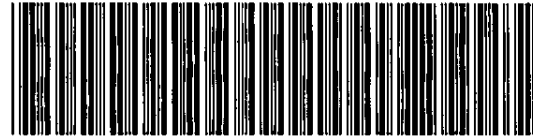
(Business Entity Name)

(Document Number)

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STATE OF FLORIDA
TALLAHASSEE, FLORIDA

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D. BRUCE

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: _____

Your Care Clinics, 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:

Milind Shastri

Name of Person

Your Care Clinics, LLC

Firm/Company

5985-49th St. North

Address

St. Petersburg, FL 33709

City/State and Zip Code

drshastri@yourcareclinics.com

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

For further information concerning this matter, please call:

Milind Shastri

Name of Person

at

727

Area Code

409-6649

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

STATE OF FLORIDA
TALLAHASSEE

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

Your Care Clinics, 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 6/17/2004 and assigned
Florida document number L04000045654.

This amendment is submitted to amend the following:

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

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)

Your Care Clinics LLC
5985-49th St. North
St. Petersburg, FL 33709

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CLERK OF CIRCUIT COURT
HILLSBORO COUNTY
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 605, 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 Authorized Member on our records, enter the title, name, and address of each Manager or Authorized Member being added or removed from our records:

MGR = Manager

AMBR = Authorized Member

<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
			<input type="checkbox"/> Add
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 13th JUDICIAL CIRCUIT
 IN AND FOR FLORIDA

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

E. Effective date, if other than the date of filing: _____ (optional)

(The effective date must be specific, cannot be prior to date of receipt or filed date and cannot be more than 90 days after the date this document is filed by the Florida Department of State)

Dated September 26, 2014.



Signature of a member or authorized representative of a member

Milind Shastri

Typed or printed name of signee

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Filing Fee: \$25.00

STATE DEPT. OF STATE
TALLAHASSEE, FLORIDA

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