

L05000031202

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐

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(Business Entity Name)

(Document Number)

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Special Instructions to Filing Officer:

W05-13230

1128

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03/11/05--01029--013 \*\*130.00

FILED  
05 MAR 28 AM 8:38  
TALLAHASSEE, FLORIDA



FLORIDA DEPARTMENT OF STATE  
Glenda E. Hood  
Secretary of State

March 14, 2005

STACY LAWRENCE  
13816 DANFORTH DR. S.  
JACKSONVILLE, FL 32224

SUBJECT: THE KYLE CLINIC PLLC  
Ref. Number: W05000013230

We have received your document for THE KYLE CLINIC PLLC and your check(s) totaling \$130.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

The specific purpose of the entity must be set forth in the document.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6890.

Jason Merrick  
Document Specialist

Letter Number: 605A00017433

SEAL OF THE  
TALLAHASSEE, FLORIDA

05 MAR 28 AM 8:38

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Here is our application for our PLLC. Any questions concerning this application please contact Stacy Lawrence. My cell phone number is (904)521-4755. My address is 13816 Danforth Dr. S. Jacksonville, FL 32224. Thank you.

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05 MAR 28 AM 8:39

SEALING  
TALLAHASSEE, FLORIDA

## TRANSMITTAL LETTER

TO: Registration Section  
Division of Corporations

SUBJECT: THE KYLE CLINIC PLLC  
(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:

STACY LAWRENCE  
(Name of Person)

THE KYLE CLINIC PLLC  
(Firm/Company)

13816 Danforth Dr. S.  
(Address)

Jacksonville, FL 32224  
(City/State and Zip Code)

For further information concerning this matter, please call:

STACY LAWRENCE at ( 904 ) 223-4569  
(Name of Person) (Area Code & Daytime Telephone Number)

Enclosed is a check for the following amount:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> \$125.00 Filing Fee | <input checked="" type="checkbox"/> \$130.00 Filing Fee & Certificate of Status | <input type="checkbox"/> \$155.00 Filing Fee & Certified Copy<br>(additional copy is enclosed) | <input type="checkbox"/> \$160.00 Filing Fee, Certificate of Status & Certified Copy<br>(additional copy is enclosed) |
|--|---|--|---|

**STREET ADDRESS:**  
Registration Section  
Division of Corporations  
409 E. Gaines Street  
Tallahassee, Florida 32399

**MAILING ADDRESS:**  
Registration Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, Florida 32314

05 MAR 28 AM 8:39  
TALLAHASSEE, FL 32314  
SECRET

FILED

## ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

### ARTICLE I - Name:

The name of the Limited Liability Company is:

THE KYLE CLINIC PLLC

### ARTICLE II - Address:

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

#### Principal Office Address:

1466 3<sup>rd</sup> St. SOUTH  
JACKSONVILLE BEACH, FL 32250

#### Mailing Address:

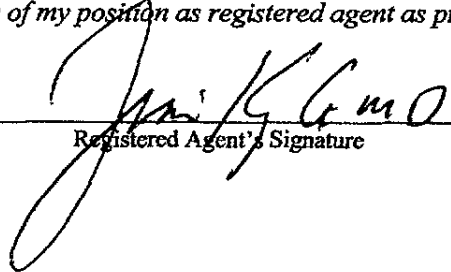
P.O. Box 51371  
JACKSONVILLE BEACH, FL 32240

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

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

DR. JAMES KYLE  
Name  
184 LAUREL LANE  
Florida street address (P.O. Box **NOT** acceptable)  
PONTE VEDRA FL 32082  
City, State, and 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 608, F.S..

  
Registered Agent's Signature

(CONTINUED)

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05 MAR 28 AM 8:09  
TALLAHASSEE, FLORIDA

**ARTICLE IV- Manager(s) or Managing Member(s):**

The name and address of each Manager or Managing Member is as follows:

**Title:**

"MGR" = Manager

"MGRM" = Managing Member

**Name and Address:**

MGRM

DR JAMES KYLE

184 LAUREL LANE

Ponte Vedra, FL 32082

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

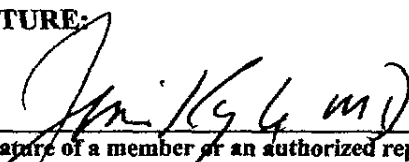
\_\_\_\_\_

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(Use attachment if necessary)

**NOTE:** An additional article must be added if an effective date is requested.

**REQUIRED SIGNATURE:**

  
\_\_\_\_\_  
Signature of a member or an authorized representative of a member.

(In accordance with section 608.408(3), Florida Statutes, the execution of this document constitutes an affirmation under the penalties of perjury that the facts stated herein are true.)

JAMES KYLE

Typed or printed name of signee

**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)**

TALLAHASSEE, FLORIDA

05 MAR 28 AM 8:39

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Purpose of Entity:

The Kyle Clinic PLLC is an Athletic and Recreational Sports Medicine Office.

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05 MAR 28 AM 8:39

SEALY COUNTY CLERK  
TALLAHASSEE, FLORIDA