

L05 0000-79258

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP     WAIT     MAIL

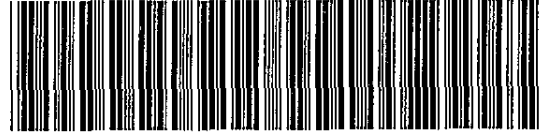
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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SECRETARY OF STATE  
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CORPDIRECT AGENTS, INC. (formerly CCRS)  
515 EAST PARK AVENUE  
TALLAHASSEE, FL 32301  
222-1173

FILING COVER SHEET  
ACCT. #FCA-14

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CONTACT: TRICIA TADLOCK

DATE: 08-11-05

REF. #: 000177.41223

CORP. NAME: MOUNT SINAI MEDICAL CENTER PHYSICIAN PRACTICES, LLC

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ARTICLES OF INCORPORATION   | <input type="checkbox"/> ARTICLES OF AMENDMENT  | <input type="checkbox"/> ARTICLES OF DISSOLUTION      |
| <input type="checkbox"/> ANNUAL REPORT               | <input type="checkbox"/> TRADEMARK/SERVICE MARK | <input type="checkbox"/> FICTITIOUS NAME              |
| <input type="checkbox"/> FOREIGN QUALIFICATION       | <input type="checkbox"/> LIMITED PARTNERSHIP    | <input checked="" type="checkbox"/> LIMITED LIABILITY |
| <input type="checkbox"/> REINSTATEMENT               | <input type="checkbox"/> MERGER                 | <input type="checkbox"/> WITHDRAWAL                   |
| <input type="checkbox"/> CERTIFICATE OF CANCELLATION |   |   |
| <input type="checkbox"/> OTHER:                      |   |   |

STATE FEES PREPAID WITH CHECK# 513756 FOR \$ 125.00.

AUTHORIZATION FOR ACCOUNT IF TO BE DEBITED:

\_\_\_\_\_ COST LIMIT: \$ \_\_\_\_\_

PLEASE RETURN:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CERTIFIED COPY        | <input type="checkbox"/> CERTIFICATE OF GOOD STANDING | <input checked="" type="checkbox"/> PLAIN STAMPED COPY |
| <input type="checkbox"/> CERTIFICATE OF STATUS |   |  |

Examiner's Initials

**ARTICLES OF ORGANIZATION  
OF  
MOUNT SINAI MEDICAL CENTER PHYSICIAN PRACTICES,  
LLC**

The undersigned, being authorized to execute and file these Articles of Organization of MOUNT SINAI MEDICAL CENTER PHYSICIAN PRACTICES, LLC (the "Limited Liability Company"), hereby certifies that:

ARTICLE I — Name:

The name of the Limited Liability Company is:

MOUNT SINAI MEDICAL CENTER PHYSICIAN PRACTICES, LLC

ARTICLE II — Address:

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

c/o Mount Sinai Medical Center  
4300 Alton Road  
Warner Building, Fifth Floor  
Attention: Wayne Chutkan  
Miami Beach, Florida 33140

ARTICLE III — Duration:

The period of duration for the Limited Liability Company shall be perpetual.

ARTICLE IV — Registered Agent:

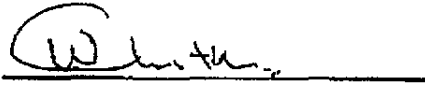
The name and address of the registered agent for service of process in the state shall be:

Wayne Chutkan  
c/o Mount Sinai Medical Center  
4300 Alton Road  
Warner Building, Fifth Floor  
Miami Beach, Florida 33140

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ARTICLE V — Management:


The Limited Liability Company will be a member-managed company.

A handwritten signature in black ink, appearing to read "W Chutkan", is written over a solid horizontal line.

Wayne Chutkan  
Authorized Signatory

**STATEMENT ACCEPTING APPOINTMENT AS REGISTERED AGENT  
MOUNT SINAI MEDICAL CENTER PHYSICIAN PRACTICES, LLC**

*Having been named as registered agent and to accept service of process for the above-stated limited liability company at the place designated by 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 the obligations of my position as a registered agent as provided for in Chapter 608, F.S.*

  
\_\_\_\_\_  
Wayne Chutkan

Dated: August 11, 2005