

LO6000040395

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(Address)

(Address)

(City/State/Zip/Phone #)

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SECRETARY OF STATE
DIVISION OF CORPORATION
10 NOV 30 PM 3:59

N. Culligan NOV 30 2010



FLORIDA DEPARTMENT OF STATE
Division of Corporations

November 12, 2010

TERRY FIELDS
4620 NORTH STATE ROAD 7
BUILDING H, SUITE 316
LAUDERDALE LAKES, FL 33319

SUBJECT: PEDIATRIC ASSOCIATES PROVIDER SERVICES NETWORK, LLC
Ref. Number: L06000040395

We have received your document for PEDIATRIC ASSOCIATES PROVIDER SERVICES NETWORK, LLC and your check(s) totaling \$35.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

We are enclosing the proper form(s) with instructions for your convenience.

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) 245-6067.

Neysa Culligan
Regulatory Specialist II

Letter Number: 310A00026596

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: Pediatric Associates Provider Services Network, LLC.
Name of Limited Liability Company

Dear Sir or Madam:

The enclosed Registered Agent/Registered Office Change and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Terry Fields
Name of Person

Pediatric Associates
Firm/Company

4620 North State Road 7 Building H, Suite 316
Address

Lauderdale Lakes, FL 33319
City/State and Zip Code

pceballos@pediatricassociates.com
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Terry Fields at (954) 965-7380
Name of Person Area Code & Daytime Telephone Number

STREET/COURIER ADDRESS:

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

MAILING ADDRESS:

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

Enclosed is a check for the following amount:

☒ \$25 Filing Fee

☐ \$55 Filing Fee & Certified Copy

STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT OR BOTH FOR LIMITED LIABILITY COMPANY

Pursuant to the provisions of sections 608.416 or 608.508, Florida Statutes, the undersigned limited liability company submits the following statement in order to change its registered office or registered agent, or both, in the State of Florida.

1. Name of the limited liability company: Pediatric Associates Provider Services Network, LLC

2. (a) Principal office address of limited liability company: 4620 North State Rd 7

(Note: **MUST BE STREET ADDRESS**)

Building H, Suite 316
Lauderdale Lakes, FL 33319

(b) Mailing address of limited liability company: 4620 North State Rd 7

(Note: **MAY BE POST OFFICE BOX**)

Building H, Suite 316
Lauderdale Lakes, FL 33319

04/19/2006

3. Date of filing/registration in Florida

L06000040395

4. Document number

5. (a) Registered Agent and Registered Office shown on the records of the Florida Dept. of State:

Registered Agent:

Gregory Taylor

Registered Office Address:

c/o Pediatric Associates
4620 North State Rd 7 Bldg H Suite 316
Lauderdale Lakes, FL 33319

(b) Enter name of **NEW Registered Agent** and/or **NEW Registered Office address**:

NEW Registered Agent:

Terry Fields

NEW Registered Office Address:

(**MUST BE FLORIDA STREET ADDRESS**)

c/o Pediatric Associates
4620 North State Rd 7 Bldg H Suite 316
Lauderdale Lakes, FL 33319

If the limited liability company is not organized under the laws of the State of Florida, it is hereby confirmed that after the change or changes are made, the Florida street address of the registered office and the business office of the registered agent will be identical. Or, in the case of a Florida limited liability company, it is hereby confirmed that the change(s) was/were authorized by an affirmative vote of the members of the limited liability company or as otherwise provided in the articles of organization or the operating agreement of the limited liability company.

Peter J. Shulman, M.D.
Signature of a member or authorized representative of a member

Peter J. Shulman, M.D. CEO

Printed or typed name of signee

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 608, 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.

J. Shulman
Signature of Registered Agent

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

FILING FEE: \$25.00