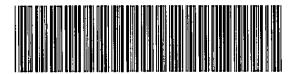
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(Requestor's Name)
(Address)
(Address)
(City/State/Zip/Phone #)
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PICK-UP WAIT MAIL
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COVER LETTER .

TO: Registration Section Division of Corporations

CR2E079 (2/14)

SUBJECT: Complete Programmed Liability Cor	sicions Billing	
The enclosed member, resignation or dissociation and fee(s		
Please return all correspondence concerning this matter to:		
Jara Denry (Contact Person)	_	
Conder Physicians Bull	ing LLC	
18147 Miramar A	ul	
P. C. A. 33954 (City/State and Zip Code)	_	
For further information concerning this matter, please call:		
(Name of Contact Person) at (Area Code	200-1901 & Daytime Telephone Number)	
Enclosed please find a check made payable to the Florida D \$25 Filing Fee \$55 Filing	Department of State for: Fee & Certified Copy	
STREET/COURIER ADDRESS: Registration Section Division of Corporations Clifton Building	MAILING ADDRESS: Registration Section Division of Corporations P.O. Box 6327	
2661 Executive Center Circle Tallahassee, Florida 32301	Tallahassee, Florida 32314	





FLORIDA DEPARTMENT OF STATE DIVISION OF CORPORATIONS

DISSOCIATION OR RESIGNATION OF MEMBER, MANAGER FROM FLORIDA OR FOREIGN LIMITED LIABILITY COMPANY

(Pursuant to 605.0216, Florida Statutes)

1. The name of the of State is:	limited liability company as it appears on the records of the Florida Department
2. The Florida docu	ment/registration number assigned to this limited liability company is:
_~010	10010334
4.1. Jara	mber/manager withdrew/resigned or will withdraw/resign is: \(\square\) \(\square\) \(\square\) hereby withdraw/resign as a ume of Person Resigning)
_ M(Print Title)
of this limited liab	sility company and affirm the limited liability company has been notified of my ting.
Lae	a Lala
Signature of Dis	sociating Member or Resigning Manager
Filing Fee: Certified Copy:	\$25.00 (Required) \$30.00 (Optional)
continue copy.	φυσιου (Optional)