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## COVER LETTER

**TO: Registration Section  
Division of Corporations**

**SUBJECT: FLORIDA PHYSICIANS, LLC**  
(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:

**FIDEL RODRIGUEZ**

(Name of Person)

**FLORIDA PHYSICIANS, LLC**

(Firm/Company)

**700 S. ROYAL POINCIANA BLVD, SUITE 506**

(Address)

**MIAMI, FL 33166**

(City/State and Zip Code)

For further information concerning this matter, please call:

**FIDEL RODRIGUEZ**

(Name of Person)

at ( **305** ) **779-1761**

(Area Code & Daytime Telephone Number)

Enclosed is a check for the following amount:

- ☐ \$125.00 Filing Fee    ☒ \$130.00 Filing Fee & Certificate of Status    ☐ \$155.00 Filing Fee & Certified Copy (additional copy is enclosed)    ☐ \$160.00 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

## ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

### ARTICLE I - Name:

The name of the Limited Liability Company is:

**FLORIDA PHYSICIANS, LLC**

(Must end with the words "Limited Liability Company," "L.L.C.," or "LLC.")

### ARTICLE II - Address:

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

#### Principal Office Address:

700 S. ROYAL POINCIANA BLVD  
SUITE 506  
MIAMI, FL 33166

#### Mailing Address:

700 S. ROYAL POINCIANA BLVD  
SUITE 506  
MIAMI, FL 33166

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

(The Limited Liability Company cannot serve as its own Registered Agent. You must designate an individual or another business entity with an active Florida registration.)

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

**ROBERT TRINKA**

Name

**700 S. ROYAL POINCIANA BLVD, SUITE 506**

Florida street address (P.O. Box **NOT** acceptable)

**MIAMI, FL 33166**

City, State, and Zip

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SECRETARY  
DIVISION OF  
CORPORATION

*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 (REQUIRED)

(CONTINUED)

**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

PHYSICIANS HEALTHCARE MANAGEMENT GROUP, INC.

700 S. ROYAL POINCIANA BLVD, SUITE 506

MIAMI, FL 33166

\_\_\_\_\_

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(Use attachment if necessary)

**ARTICLE V:** Effective date, if other than the date of filing: \_\_\_\_\_. (OPTIONAL)

(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**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.)

ROBERT TRINKA, PRESIDENT OF PHYSICIANS HEALTHCARE MGMT GRP

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)**