

L08000079261

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

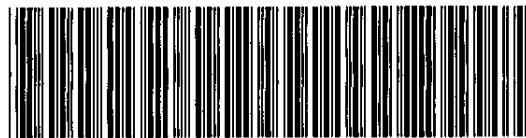
(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer:

Office Use Only



400134417424

08/20/08--01005--002 **125.00

RECEIVED

08 AUG 20 AM 9:45

DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
TALLAHASSEE, FLORIDA

FILED

08 AUG 20 AM 9:45

DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA

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

FILING COVER SHEET
ACCT. #FCA-14

CONTACT: KATIE WONSCH

DATE: 08/20/08

REF. #: 000177.91265

CORP. NAME: MID-FLORIDA ORTHOPAEDIC PHYSICIAN SERVICES, L.L.C.

FILED
08 AUG 20 AM 9:15
TALLAHASSEE, FLORIDA

- | | | |
|--|---|---|
| <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# 527226 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
MID-FLORIDA ORTHOPAEDIC PHYSICIAN SERVICES, L.L.C.**

The undersigned, being authorized to execute and file these Articles of Organization of **MID-FLORIDA ORTHOPAEDIC PHYSICIAN SERVICES, L.L.C.** (the "Limited Liability Company"), hereby certifies that:

ARTICLE I — Name:

The name of the Limited Liability Company is:

MID-FLORIDA ORTHOPAEDIC PHYSICIAN SERVICES, L.L.C.

ARTICLE II — Address:

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

200 Avenue F Northeast
Winter Haven, Florida 33881

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:

Lance W. Anastasio
200 Avenue F Northeast
Winter Haven, Florida 33881


ARTICLE V — Management:

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

ARTICLE VI — Indemnification

The Limited Liability Company shall indemnify and hold harmless its members against any and all claims and demands whatsoever.

FILED
08 AUG 20 AM 9:45
TALLAHASSEE, FLORIDA


Lance W. Anastasio
Authorized Signatory

STATEMENT ACCEPTING APPOINTMENT AS REGISTERED AGENT

MID-FLORIDA ORTHOPAEDIC PHYSICIAN SERVICES, L.L.C.

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.



Lance W. Anastasio

Dated: August 18, 2008