

L10000003326

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

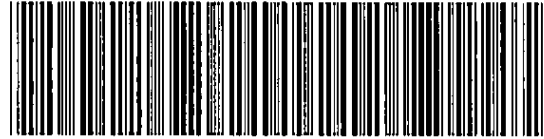
(Business Entity Name)

(Document Number)

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SECRETARIAL SERVICES  
TALLAHASSEE, FLORIDA

Y 2021

# CT CORP

3458 Lakeshore Drive, Tallahassee, FL 32312  
850-656-4724

Date: 09/09/2021

Acc#120160000072

*en: c DW*

|             |                                       |
|-------------|---------------------------------------|
| Name:       | Gulf Coast Inpatient Specialists, LLC |
| Document #: |                                       |
| Order #:    | 13867026- 3 / 7                       |

|                                   |                          |                         |  |
|-----------------------------------|--------------------------|-------------------------|--|
| Certified Copy of Arts & Amend:   | <input type="checkbox"/> |                         |  |
| Plain Copy:                       | <input type="checkbox"/> |                         |  |
| Certificate of Good Standing:     | <input type="checkbox"/> |                         |  |
| Certified Copy of:                | <input type="checkbox"/> |                         |  |
| Apostille/Notarial Certification: | <input type="checkbox"/> | Country of Destination: |  |
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|---------------------|
| Availability _____  |
| Document _____      |
| Examiner _____      |
| Updater _____       |
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| W.P. Verifier _____ |
| Ref# _____          |

Amount: \$ 55.00

Thank you!

## COVER LETTER

**TO:** Registration Section  
Division of Corporations

**SUBJECT:** Gulf Coast Inpatient Specialists, LLC  
Name of Limited Liability Company

Dear Sir or Madam:

The enclosed Statement of Termination and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Ceci Estill

Name of Person

c/o Gulf Coast Inpatient Specialists, LLC

Firm/Company

One Park Plaza

Address

Nashville, TN 37203

City/State and Zip Code

shirley.scharf@hcahealthcare.com

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Ceci Estill at (615) 344-2994  
Name of Person Area Code Daytime Telephone Number

**Mailing Address:**

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

**Street Address:**

Registration Section  
Division of Corporations  
The Centre of Tallahassee  
2415 N. Monroe Street, Suite 810  
Tallahassee, FL 32303

## STATEMENT OF TERMINATION

Pursuant to section 605.0709(7), Florida Statutes, I hereby submit the following Statement of Termination:

**FIRST:** The name of the limited liability company is: Gulf Coast Inpatient Specialists, LLC

**SECOND:** The Florida Document number of the limited liability company is: L10000003326

**THIRD:** The date of filing of the initial articles of organization is: 01/08/2010

**FOURTH:** The date of filing of the dissolution is: 09/09/2021

**FIFTH:** This limited liability company has completed winding up its activities and affairs and has determined that it will file a statement of termination.

Natalie H. Cline  
Signature of Authorized Representative

Natalie H. Cline  
Typed or printed name of signature

Filing Fee: \$25.00  
Certified Copy: \$30.00 (optional)

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2021 SEP -9 AM 8:10  
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TAMPA, FL