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(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

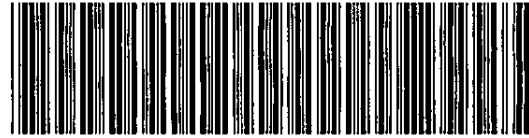
(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

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TALLAHASSEE, FLORIDA

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T CLINE



**CENTER FOR VEIN &
VASCULAR DISEASE**

450 W. Central Parkway Suite 2001
Altamonte Springs, FL 32714
Phone: (407)865-7091
Fax: (407) 865-7090

Kishore Ranadive M.D., F.A.C.C., F.S.C.A.I.

Babak Alex Vakili M.D., F.A.C.C., F.S.C.A.I.

Florida Department of State
Division of Corrections
P.O Box 6198
Tallahassee, FL 32314

Enclosed is the registration for our company's name change. If any further questions please contact Mary Henry (407) 767-8554 ext.: 7018.

Sincerely,
Princess Hernandez

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TALLAHASSEE, FLORIDA

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: CENTER FOR VASCULAR AND VEIN DISEASE LLC

Name of Limited Liability Company

The enclosed Articles of Amendment and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

BABAK VAKILI

Name of Person

CENTER FOR VASCULAR AND VEIN DISEASE LLC

Firm/Company

450 W CENTRAL PARKWAY SUITE 2000

Address

ALTAMONTE SPRINGS FL 32714

City/State and Zip Code

BVAKILI@ME.COM

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

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SECRETARY OF STATE
TALLAHASSEE, FL 32301

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For further information concerning this matter, please call:

BABAK VAKILI

at (407) 928-7123

Name of Person

Area Code

Daytime Telephone Number

Enclosed is a check for the following amount:

- | | | | |
|--|--|--|--|
| <input checked="" type="checkbox"/> \$25.00 Filing Fee | <input type="checkbox"/> \$30.00 Filing Fee &
Certificate of Status | <input type="checkbox"/> \$55.00 Filing Fee &
Certified Copy
(additional copy is enclosed) | <input type="checkbox"/> \$60.00 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

CENTER FOR VASCULAR AND VEIN DISEASE LLC

Page 1 of 3

If amending the Managers or Authorized Member on our records, enter the title, name, and address of each Manager or Authorized Member being added or removed from our records:

MGR = Manager

AMBR = Authorized Member

<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
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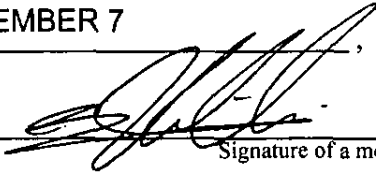
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 SECRETARY OF STATE
 1401 MASSACHUSETTS AVENUE
 BOSTON, MA 02125

D. If amending any other information, enter change(s) here: *(Attach additional sheets, if necessary.)*

E. Effective date, if other than the date of filing: _____ (optional)

(The effective date must be specific, cannot be prior to date of receipt or filed date and cannot be more than 90 days after the date this document is filed by the Florida Department of State)

Dated NOVEMBER 7, 2014



Signature of a member or authorized representative of a member

BABAK VAKILI

Typed or printed name of signer

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TALLAHASSEE, FLORIDA

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