

L 120000001401

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

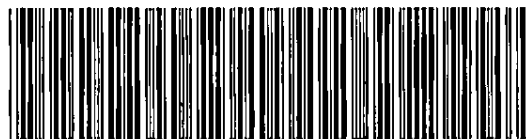
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

Special Instructions to Filing Officer:

Office Use Only



700357161937

FILED  
2021 JAN -6 AM 8:55  
SECRETARY OF STATE  
TALLAHASSEE, FL

FILED  
2021 JAN -6 PM 4:13  
TALLAHASSEE, FL

**Sunshine State Corporate Compliance Company**

3458 Lakeshore Drive, Tallahassee, Florida 32312

(850) 656-4724

DATE 01/06/2021

**\*\*WALK IN\*\***

ENTITY NAME OPTIMUM HEALTHCARE IT, LLC

DOCUMENT NUMBER \_\_\_\_\_

**\*\*PLEASE FILE THE ATTACHED AND RETURN\*\***

XXXX

*Plain Copy*

*Certified Copy*

*Certificate of Status*

**\*\*PLEASE OBTAIN THE FOLLOWING FOR THE ABOVE ENTITY\*\***

*Certified Copy of Arts & Amendments*

*Certificate of Good Standing*

**\*\*APOSTILLE' / NOTARIAL CERTIFICATION\*\***

COUNTRY OF DESTINATION \_\_\_\_\_

NUMBER OF CERTIFICATES REQUESTED \_\_\_\_\_

TOTAL OWED \$25.00

ACCOUNT #: I20160000072

*Please call Tina at the above number for any issues or concerns. Thank you so much!*

**COVER LETTER**

**TO:** Registration Section  
Division of Corporations

**SUBJECT:** OPTIMUM HEALTHCARE IT, LLC  
Name of Limited Liability Company

Dear Sir or Madam:

The enclosed Registered Agent/Registered Office Change and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Sharon K. Gray  
Name of Person

Triad Professional Services  
Firm/Company

1720 Windward Concourse, Ste. 390  
Address

Alpharetta, GA 30005  
City/State and Zip Code

ieka.jones@wolterskluwer.com  
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Sharon K. Gray at ( 770 ) 777-2091  
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

**Enclosed is a check for the following amount:**

☒ \$25 Filing Fee

☐ \$55 Filing Fee & Certified Copy

# STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT OR BOTH FOR LIMITED LIABILITY COMPANY

Pursuant to the provisions of sections 605.0114 or 605.0116, Florida Statutes, the undersigned limited liability company submits the following statement in order to change its registered office or registered agent, or both, in the State of Florida.

1. Name of the limited liability company: Optimum Healthcare IT, LLC

2. (a) 1300 Marsh Landing Parkway (b) 1300 Marsh Landing Parkway  
Principal office address of limited liability company: Mailing address of limited liability company:  
(Note: **MUST BE STREET ADDRESS**) (Note: **MAY BE POST OFFICE BOX**)

Suite 105 Suite 105

Jacksonville, FL 32250 Jacksonville, FL 32250

3. 01/04/2012 4. L12000001401  
Date of filing/registration in Florida Document number

5. (a) KIRSCHNER, KENNETH M.  
Registered Agent and Registered Office shown on the records of the Florida Dept. of State:

1431 RIVERPLACE BOULEVARD

Registered Office Address (MUST BE FLORIDA STREET ADDRESS)

SUITE 910

JACKSONVILLE, FL 32202

(b) NRAI SERVICES, INC.

Enter name of NEW Registered Agent and/or NEW Registered Office address:

1200 SOUTH PINE ISLAND ROAD

NEW Registered Office Address:

PLANTATION, FL 33324

If the limited liability company is not organized under the laws of the State of Florida, it is hereby confirmed that after the change or changes are made, the Florida street address of the registered office and the business office of the registered agent will be identical. Or, in the case of a Florida limited liability company, it is hereby confirmed that the change(s) was/were authorized by an affirmative vote of the members of the limited liability company or as otherwise provided in the articles of organization or the operating agreement of the limited liability company.

DocuSigned by:  
Lydia Veal Lydia Veal  
Signature of a member or authorized representative of a member Printed or typed name of signee

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 relative 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 605, F.S. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.

DocuSigned by:  
Sharon K. Gray  
Signature of Registered Agent

S420D001C2C542C

Division of Corporations • P.O. Box 6327 • Tallahassee, FL 32314  
FILING FEE: \$25.00