PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETINGTHIS FORM

LIMITED LIABILITY COMPANY
~~**REINSTATEMENT**~~
Annual Report

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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CR2E041 (1/14)

DOCUMENT # L12000078687

1. Limited Liability Company's Name
TOWN CENTER FAMILY MEDICINE, LLC

2. Principal Office Address - No P.O. Box #		3. Mailing Office Address	
610 SYCAMORE STREET		610 SYCAMORE STREET	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
STE 130		STE 130	
City & State		City & State	
CELEBRATION, FL		CELEBRATION, FL	
Zip	Country	Zip	Country
34747	USA	34747	USA

4. State/Country of Formation
FL

5. Date Organized or Qualified To Do Business in Florida 06/12/2012

6. FEI Number
90-0856965
☐ Applied For
☐ Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐ **$5.00 Additional Fee required for a certificate of status**

8. **Name and Address of Current Registered Agent**

Name
CHAD BLACK

Street Address (P.O. Box Number is Not Acceptable) Suite
610 SYCAMORE STREET

Apt #, Etc.
STE 130

City	State	Zip Code
CELEBRATION	FL	34747

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S.

Signature of Registered Agent _____ Date 10/05/2016
REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Authorized Representatives/Managers

Titles	Name of Authorized Representatives/ Managers	Street Address of Each Authorized Representative/ Manager	City / State / Zip
P	CHAD BLACK	610 SYCAMORE STREET STE 130	CELEBRATION, FL 34747

11. E-mail Address: TENNILLE10@GMAIL.COM
(To be used for future annual report notifications)

12. I certify that I am an authorized representative/ manager or the receiver or trustee empowered to execute this application as provided for in Chapter 605, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirement of section 605.0012, F.S., and that all fees owed by the limited liability company have been paid. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s 817.155, F.S.

Signature of authorized representative/member _____ Date 10/11/16 Daytime Phone # 321-287-6955

Typed or printed name of signing authorized representative/member CHAD BLACK, D.O.