

#L12000110037

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

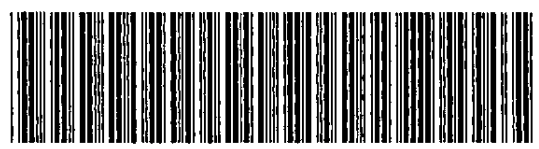
(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer:

Office Use Only



700251057207

09/03/13--01041--002 **185.00

FILED
13 SEP - 3 PM 3:55
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

K. SALY
EXAMINER
SEP - 5 2013

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: PHYSICIANS COLLABORATIVE TRUST ACO, 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:

LARRY E. JONES
Name of Person

PHYSICIANS COLLABORATIVE TRUST ACO, LLC
Firm/Company

1101 N. LAKE DESTINY DR., # 300
Address

MAITLAND, FL 32751
City/State and Zip Code

LJONES@PCT-ACO.COM
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

LARRY E. JONES at (407) 475-9213
Name of Person Area Code & Daytime Telephone Number

STREET/COURIER ADDRESS:

Registration Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, Florida 32301

MAILING ADDRESS:

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

Enclosed is a check for the following amount:

☒ \$25 Filing Fee

☐ \$55 Filing Fee & Certified Copy

Pursuant to the provisions of sections 608.416 or 608.508, 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.

- NHS 18 (05/08)**