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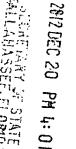
(Requestor's Name)
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(Address)
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(City/State/Zip/Phone #)
PICK-UP WAIT MAIL
(Business Entity Name)
(Document Number)
Certified Copies Certificates of Status
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Special Instructions to Filing Officer:
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EXAMINER
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Office Use Only



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FLORIDA DEPARTMENT OF STATE Division of Corporations

November 8, 2012

SHERIEF KAMEL, M.D. 155 CRYSTAL BEACH DRIVE 1-B DESTIN, FL 32541-3527

SUBJECT: THE DIABETES AND ENDOCRINE CLINIC, P.L.L.C.

Ref. Number: W12000056735

We have received your document for THE DIABETES AND ENDOCRINE CLINIC, P.L.L.C. and your check(s) totaling \$160.00. However, the enclosed document has not been filed and is being returned for the following correction(s);

A brief description of the entity's nature of business must be included in the document.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6094.

Agnes Lunt Regulatory Specialist II

Letter Number: 412A00027187

DIABETES THYROID AND ENDOCRINE CLINIC

DR SHERIEF M. KAMEL, MD FACE ECNU

ASHLI BROOKS, ARNP

410 WEST 19TH ST.

PANAMA CITY, FL 32405

PHONE: 850-522-5490 FAX: 850-522-5491

SECRETARY O	12 DEC 14 1	RECEIV
OF STATE E. FLORIDA	AM 6: 45	VED

FAX COVER SHEET						
TO: agree Lunt	_from:_ <i>R</i> 4	rnie Diahetes di	nd Endoernie (Mine LC		
FAX: (850) 245-6030			2812 DEC	- 		
PHONE#:			5 03	F		
RE: Division Corporations Application	_FROM:	Dr Sherry h	Kanel			
THIS FAX MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION FOR THE SOLE USE OF THE INTENDED RECIPIENT, ANY REVIEW, USE, DISTRIBUTION, OR DISCLOSURE BY OTHERS IS STRICTLY PROHIBITED. IF YOU ARE NOT THE INTENDED RECIPIENT (OR AUTHORIZATION TO RECEIVE INFORMATION FOR THE INTENDED RECIPIENT), PLEASE CONTACT THE SENDER BY REPLY AND DESTROY ALL COPIES OF THIS MESSAGES, THANK YOU						
PLEASE INDICATE BY CHECKING THE LINE. BELI SENDER IMMEDIATELY ERROR MY PHONE # IS	_I HAVE REC					

COMMENTS:

COVER LETTER

TO: Registration Section Division of Corporations
SUBJECT: THE DIABETES AND ENDOCRINE CLINIC, P.L.L.C.
Name of Limited Liability Company
The second secon
The enclosed Articles of Organization and the(s) are submitted for filing.
The enclosed Articles of Organization and Rec(s) are submitted for filling. Please return all correspondence concerning this matter to the following: SHERIEF KAMEL, M.D.
SHERIEF KAMEL, M.D.
Nume of Person
THE DIABETES AND ENDOCRINE CLINIC
Firm/Company
155 CRYSTAL BEACH DRIVE & Switz 123
Adilizės
DESTIN, FL 32541-3527
City/State and Zip Code
sheriefkamel@yahoo.com E-mail address: (to be used for filture annual report notification)
Estimat display (in the presentation relieve violence and presentation)
For further information concerning this matter, please call:
BILL FETKE 850 455-7191
Name of Person Acea Code & Daytime Telephone Number
Enclosed is a check for the following amount:
S125.00 Filing Fee \$130.00 Filing Fee & \$155.00 Filing Fee & \$160.00 Filing Fee.

Mailing Aildress 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 Talluliassee, FL 32301

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

ARTICLE 1 - Name:

The name of the Limited Liability Company is:

THE DIABETES AND ENDOCRINE CLINIC, P.L.L.C.

(Must end with the words "Limited Liability Company, "L.L.C." or "LI.C.")

ARTICLE IL Address		ي 1	7
ARTICLE II - Address: The mailing address and street address of the pr	incipal office of the Limited Liability	Commany	ئے۔ **کا
	•	7	2
Principal Office Address:	Mailing Address:	まじ	
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DESTIN, FL 32541-3527

SAME 155 Crystal Beach Dr. Sule 123 Destin, 48 32541-3527

ARTICLE III - Registered Agent, Registered Office, & Registered Agent's Signature: (The Limited Limbility Company cannot serve as its own Registered Agent. You must designate an individual or another business onlity with an active Florida registration.)

The name and the Florida street address of the registered agent are:

BILL FETKE Name

6866 PINE FOREST RD STE A

Florida street address (P.O. Box NOT acceptable)

PENSACOLA FL 32526
City, State, and Zap

Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate. 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 relating to the proper and complete performance of my duties, and I amfamiliar with and accept the obligations of my position as registered agent as provided for in Chapter 608, F.S.

Registered Agent's Signature (REQUIRED)

(CONTINUED)

Page 1 of 2

<u>Title:</u>	Name and Address:
"MGR" = Manager	,
"MGRM" = Managing Member	
MGR	
	SHERIEF KAMEL
	155 CRYSTAL BEACH DR TE DESTIN, FL 32541
	155 Crystal Beach Dr. Suite 123
**************************************	135 Vagiac / Race pt. sun 125
	2812 DEC
(The attachment if accounts)	en e
(Use attachment if necessary)	+
ARTICLE V: Effective date, if other than the	ne date of filing: UM (OPTIONAL)
(If an effective date is listed, the date must	be specific and cannot be more than five business days prior
to or 90 days after the date of filing.)	·
,	
REQUIRED SIGNATURE:	
The state of the s	• / /
	_/ /
	be be in withorized representative of a member.
(In accordance with section 6	08 408(3). Florida Statutes, the execution of this desument ded the penalties of perjury that the facts stated herein are true.
I am aware that any felse info	ormation submitted in a dogument to the Department of State
constitutes a third degree felo	ony as provided for in s.817.155, F.S.)

Filing Fees:

S125:00 Filing Fee for Articles of Organization and Designation of Registered Agent \$ 30.00 Certified Copy (Optional)

SHERIEF KAMEL, M.D.

\$ 5.00 Certificate of Status [Optional)

Typed or printed name of signee

* purpose of office: medical office