

L13000017987

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

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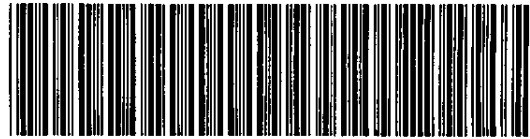
(Business Entity Name)

(Document Number)

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2014 FEB 14 AM 10:46  
STATE TREASURER  
TALLAHASSEE, FLORIDA

FEB 17 2014  
D. BRUCE

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT: Accident & Anti Aging Clinic 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:

**Dr. Benoit O. Choiniere**

Name of Person

**Accident & Anti Aging Clinic LLC**

Firm/Company

**1501 S. Missouri Ave**

Address

**Clearwater, FL 33756**

City/State and Zip Code

**drbenc@msn.com**

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

For further information concerning this matter, please call:

**Dr. Benoit O. Choiniere**

Name of Person

at ( **727** ) **488-8044**

Area Code

Daytime Telephone Number

Enclosed is a check for the following amount:

- ☒ \$25.00 Filing Fee      ☐ \$30.00 Filing Fee & Certificate of Status      ☐ \$55.00 Filing Fee & Certified Copy (additional copy is enclosed)      ☐ \$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

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

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**ARTICLES OF AMENDMENT  
TO  
ARTICLES OF ORGANIZATION  
OF**

**ACCIDENT & ANTI AGING CLINIC, LLC**

(Name of the Limited Liability Company as it now appears on our records.)  
(A Florida Limited Liability Company)

The Articles of Organization for this Limited Liability Company were filed on 02/05/2013 and assigned  
Florida document number L13000017987.

This amendment is submitted to amend the following:

**A. If amending name, enter the new name of the limited liability company here:**

**TEAM PHYSICIANS OF FLORIDA, LLC**

The new name must be distinguishable and end with the words "Limited Liability Company," the designation "LLC" or the abbreviation "L.L.C."

**Enter new principal offices address, if applicable:**

**(Principal office address MUST BE A STREET ADDRESS)**

**Enter new mailing address, if applicable:**

**(Mailing address MAY BE A POST OFFICE BOX)**

**B. If amending the registered agent and/or registered office address on our records, enter the name of the new registered agent and/or the new registered office address here:**

Name of New Registered Agent:

New Registered Office Address:

*Enter Florida street address*

\_\_\_\_\_, **Florida** \_\_\_\_\_  
City Zip Code

**New Registered Agent's Signature, if changing Registered Agent:**

*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.*

**If Changing Registered Agent, Signature of New Registered Agent**

**MGR = Manager**  
**AMBR = Authorized Member**

[illegible]

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U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

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

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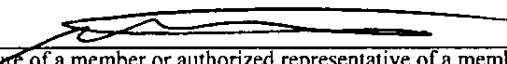
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**E. Effective date, if other than the date of filing:** \_\_\_\_\_ **(optional)**

(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 Feb. 11<sup>th</sup>, 2014.

  
\_\_\_\_\_  
Signature of a member or authorized representative of a member

**Dr. Benoit O. Choiniere**

\_\_\_\_\_  
Typed or printed name of signee

**Page 3 of 3**

**Filing Fee: \$25.00**

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TALLAHASSEE FLORIDA