

LI300006874

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

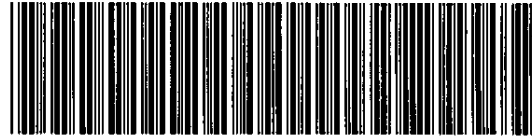
(Business Entity Name)

(Document Number)

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TALLAHASSEE, FLORIDA

COVER LETTER

**TO: Registration Section
Division of Corporations**

SUBJECT: HealthCare Partners Family Practice

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:

Sheila Keene-Lund

Name of Person

HealthCare Partners Family Medicine

Firm/Company

1501 HWY 441 N, Suite 1704

Address

The Villages, FL, 32159

City/State and Zip Code

sklund@md-one.net

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

For further information concerning this matter, please call:

Sheila Keene-Lund

Name of Person

at **352** **750-4333 x 201**

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

HealthCare Partners Family Practice, LLC

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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Code

If amending the Managers or Authorized Member on our records, enter the title, name, and address of each Manager or Authorized Member being added or removed from our records:

MGR = Manager

AMBR = Authorized Member

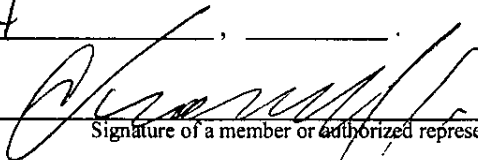
<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<input type="checkbox"/> Add
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D. If amending any other information, enter change(s) here: *(Attach additional sheets, if necessary.)*

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 9/29/14



Signature of a member or authorized representative of a member

NELSON KRAUCAK, MD

Typed or printed name of signee

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