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(Requestor's Name)					
(Address)					
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(Cit	y/State/Zip/Phone	#)			
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COVER LETTER

TO:	Regi	stration Section		
	Divis	sion of Corporations		
SUBJ	TECT:	IMAGING MEDICAL CEN		
		(Name of I	Limited Liability Con	npany)
The e	nclosed	d member, resignation or disse	ociation and fee(s	e) are submitted for filing.
Please	e returr	all correspondence concerni	ng this matter to:	
ERIK	A ARA	OLUA		
		(Contact Person)	· -	_
		(Firm/Company)		_
2411	W SA	ND LAKE ROAD		
	<u> </u>	(Address)		_
ORL	ANDO	FL, 32809		
		(City/State and Zip Code)		_
For fu	ırther i	nformation concerning this ma	atter, please call:	
ERIK	A ARA	OLUA	407 at (259-2626
	(N	ame of Contact Person)		& Daytime Telephone Number)
	sed ple 5 Filing	ase find a check made payabl g Fee		Department of State for: Fee & Certified Copy
		OURIER ADDRESS:		MAILING ADDRESS:
_		Section		Registration Section
	ion of C n Build	Corporations		Division of Corporations P.O. Box 6327
		ive Center Circle		Tallahassee, Florida 32314
		Florida 32301		rananassoo, i foliaa 32314

CR2E079 (2/14)



FLORIDA DEPARTMENT OF STATE DIVISION OF CORPORATIONS

DISSOCIATION OR RESIGNATION OF MEMBER, MANAGER FROM FLORIDA OR FOREIGN LIMITED LIABILITY COMPANY

(Pursuant to 605.0216, Florida Statutes)

			10 E
1. The name of the	limited liability company as it	appears on the records of the Florida De	partment
of State is:	GING MEDICAL CENTER L	LC	Coixi
of State is,			
2. The Florida doc	ument/registration number assi	gned to this limited liability company is:	2
L1300013816	·	, , ,	Caire or Allows
	 	<u></u> ·	
3. The date this me	ember/manager withdrew/resign	ned or will withdraw/resign is:	117
4. I,		, hereby withdraw/resign as a	
(Print l	Name of Person Resigning)		
MANAGER			
	(Print Title)		
of this limited lia	ability company and affirm the I	limited liability company has been notifie	ed of mv
resignation in wr		The state of the s	.u o,
_	_		
	Laup		
Signature of D	issociating Member or Resignin	ng Manager	
Filing Fee:	\$25.00 (Required)		
Certified Conv:	\$30.00 (Optional)		