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K. SALY
EXAMINER
MAY 26 2015

COVER LETTER

**TO: Registration Section
Division of Corporations**

SUBJECT: HOLISTIX MEDICAL GROUP 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:

Name of Person

HOLISTIX MEDICAL GROUP LLC

Firm/Company

803 NW 2ND AVENUE

Address

POMPANO BEACH FL 33060

City/State and Zip Code

INFO@HOLISTIXBYTHESEA.COM

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

For further information concerning this matter, please call:

Name of Person

at (_____) _____

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

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TALLAHASSEE, FLORIDA
rds.)

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

If amending Authorized Person(s) authorized to manage, enter the title, name, and address of each person 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>
			☐ Add
			☐ Remove
			☐ Change
			☐ Add
			☐ Remove
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If the record specifies a delayed effective date, but not an effective time, at 12:01 a.m. on the earlier of:

(b) The 90th day after the record is filed.

Dated MAY 18

2015

_____, 2015



Signature of a member or authorized representative of a me

Signature of a member or authorized representative of a member

Francis Zofay

Typed or printed name of signee