

L14000110129

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐

PICK-UP

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WAIT

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MAIL

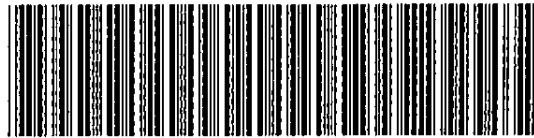
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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FILED  
14 JUL 11 AM 9:26  
SECRETARY OF STATE  
TALLAHASSEE FLORIDA

RECEIVED  
14 JUL 11 PM 2:01  
DIVISION OF CORPORATE & FINANCIAL SERVICES

JUL 14 2014  
T. HAMPTON



CORPORATION SERVICE COMPANY

ACCOUNT NO. : I20000000195

REFERENCE : 212572 7509084

AUTHORIZATION :

COST LIMIT : \$125.00

ORDER DATE : July 11, 2014

ORDER TIME : 1:18 PM

ORDER NO. : 212572-005

CUSTOMER NO: 7509084

DOMESTIC FILING

NAME: BLUE KNOLL EMERGENCY  
PHYSICIANS, LLC

EFFECTIVE DATE:

☒ ARTICLES OF INCORPORATION  
☐ CERTIFICATE OF LIMITED PARTNERSHIP  
☒ ARTICLES OF ORGANIZATION

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

☐ CERTIFIED COPY  
☒ PLAIN STAMPED COPY  
☐ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Emily Gray - EXT. 62925

EXAMINER'S INITIALS: \_\_\_\_\_

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT: Blue Knoll Emergency Physicians, LLC**  
Name of Limited Liability Company

The enclosed Articles of Organization and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Robyn Ratton  
Name of Person

Envision Health Care  
Firm/Company

6200 S. Syracuse St 200  
Address

Greenwood Village  
City/State and Zip Code

lynne.liko@evhc.net  
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Robyn.elliott-Ratton@evhc.net at ( 303 ) 4951217  
Name of Person Area Code Daytime Telephone Number

Enclosed is a check for the following amount:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> \$125.00 Filing Fee | <input type="checkbox"/> \$130.00 Filing Fee &<br>Certificate of Status | <input type="checkbox"/> \$155.00 Filing Fee &<br>Certified Copy<br>(additional copy is enclosed) | <input type="checkbox"/> \$160.00 Filing Fee,<br>Certificate of Status &<br>Certified Copy<br>(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

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

**ARTICLE I - Name:**

The name of the Limited Liability Company is:

Blue Knoll Emergency Physicians, LLC

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

**ARTICLE II - Address:**

The mailing address and street address of the principal office of the Limited Liability Company is:

**Principal Office Address:**

6200 S Syracuse Way, Ste 200  
Greenwood Village, CO 80111

**Mailing Address:**

6200 S. Syracuse Way, Ste 200  
Greenwood Village, CO 80111  
Attn: Legal

**ARTICLE III - Registered Agent, Registered Office, & Registered Agent's Signature:**

(The Limited Liability Company cannot serve as its own Registered Agent. You must designate an individual or another business entity with an active Florida registration.)

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

Corporation Service Company

Name

1201 Hay St

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

Tallahassee

FL

City

Zip

*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 am familiar with and accept the obligations of my position as registered agent as provided for in Chapter 605, F.S.*

Emily Gray Asst VP  
Registered Agent's Signature (REQUIRED)

(CONTINUED)

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**ARTICLE IV-**

The name and address of each person authorized to manage and control the Limited Liability Company:

Title:

"AMBR" = Authorized Member

"MGR" = Manager

Member

Name and Address:

EHRA Medical Services of Florida, LLC

6200 S. Syracuse Way, Ste. 200

Greenwood Village, CO 80111

(Use attachment if necessary)

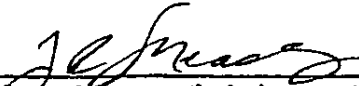
**ARTICLE V:** Effective date, if other than the date of filing: upon filing (OPTIONAL)

(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.)

**ARTICLE VI:** Other provisions, if any.

none

**REQUIRED SIGNATURE:**

\*  \*

Signature of a member or an authorized representative of a member.  
(In accordance with section 605.0203 (1) (b), Florida Statutes, the execution of this document constitutes an affirmation under the penalties of perjury that the facts stated herein are true. I am aware that any false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.)

Terry Meadows, M.D. - authorized signer

Typed or printed name of signer

**Filing Fees:**

\$125.00 Filing Fee for Articles of Organization and Designation of Registered Agent

\$ 30.00 Certified Copy (Optional)

\$ 5.00 Certificate of Status (Optional)

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