

L15000136433

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

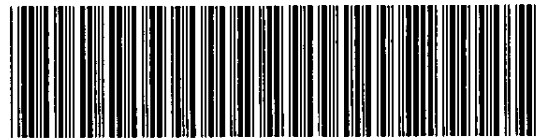
(Business Entity Name)

(Document Number)

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

Special Instructions to Filing Officer:

Office Use Only



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02/16/16--01030--017 \*\*25.00

FILED  
16 FEB 29 PM 2:03  
HALL COUNTY, FLORIDA

MAR 03 2016  
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FLORIDA DEPARTMENT OF STATE  
Division of Corporations

February 18, 2016

MS.CORINA GONZALEZ  
6437 CONROY WILDERMERE RD  
APT 1114  
ORLANDO, FL 32835

SUBJECT: FAMILY HEALTH CLINIC OF ORLANDO LLC  
Ref. Number: L15000136433

RECEIVED  
2016 FEB 29 PM 4:38  
TALLAHASSEE, FLORIDA

We have received your document for FAMILY HEALTH CLINIC OF ORLANDO LLC and your check(s) totaling \$25.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

Section 605.0203(1)(b), Florida Statutes, requires the document(s) to be signed by one person acting as an authorized representative.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6051.

Yasemin Y Sulker  
Regulatory Specialist II

Letter Number: 016A00003379

## COVER LETTER

**TO:** Registration Section  
Division of Corporations

**SUBJECT:** FAMILY HEALTH CLINIC OF ORLANDO LLC  
(Name of Limited Liability Company)

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

Please return all correspondence concerning this matter to the following:

MS. CORINA GONZALEZ

(Name of Person)

(Firm/Company)

6437 Conroy Windermere Rd Apt 1114

(Address)

Orlando, FL 32835

(City/State and Zip Code)

For further information concerning this matter, please call:

Corina Gonzalez

(Name of Person)

at ( 715 ) 650-1789

(Area Code & Daytime Telephone Number)

Enclosed is a check for the following amount:

☒ \$25.00 Filing Fee and Certificate of Dissolution

☐ \$55.00 Filing Fee, Certificate of Dissolution &  
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

**ARTICLES OF DISSOLUTION  
FOR  
A LIMITED LIABILITY COMPANY**

1. The name of a limited liability company is  
FAMILY HEALTH CLINIC OF ORLANDO LLC
2. The Articles of Organization were filed on 8/10/2015 and assigned  
document number L15000136433
3. The delayed effective date the dissolution if not effective on the date of filing: \_\_\_\_\_  
(effective date cannot be prior to or more than 90 days later than date document is received for filing)  
**Note:** If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be  
listed as the document's effective date on the Department of State's records.
4. A description of occurrence that resulted in the limited liability company's dissolution pursuant to section  
605.0707, Florida Statutes, (copy 605.0707 on back cover letter).  
ON 12/31/2015 ALL MEMBERS AGREED TO CLOSE THE BUSINESS AND DISSOLVE THE LLC.

5. If there are no members, enter the name and address of the person appointed to wind up the company,  
activities and affairs: \_\_\_\_\_

6. Signature of an authorized person or if there are no members, the signature of the person appointed and  
listed above to wind up the company's activities and affairs:

  
Signature

MS. CORINA GONZALEZ  
Printed Name

**FILING FEE: \$25.00**

FILED  
16 FEB 29 PM 2:03  
TALLAHASSEE, FLORIDA

## Notice of Limited Liability Company Dissolution

**NOTE: This page is optional**

This notice is submitted by the dissolved limited liability company named below for resolution of payment of unknown claims against this limited liability company as provided in s. 605.0712, F.S.

This "Notice of Limited Liability Company Dissolution" is optional and is not required when filing a voluntary dissolution.

Name of Limited Liability Company: FAMILY HEALTH OF ORLANDO LLC

Document number of Limited Liability Company is: L15000136433

Date of dissolution was: 12/31/2015

Description of information that must be included in a written claim:

ALL MEMBERS AGREED TO DISSOLUTION.

Mailing address where claims can be sent: (Claims cannot be sent to the Division of Corporations)

6437 CONROY WINDERMERE RD

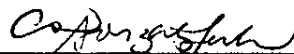
APT 1114

ORLANDO FL 32835

A claim against the above named limited liability company will be barred unless a proceeding to enforce the claim is commenced within 4 years after the filing of this notice.

MS. CORINA GONZALEZ

Printed Name of the Person Filing



Signature of the Person Filing

Fee: No charge if included with Articles of Dissolution. If filed separately \$25.00