

L16000211250

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DEPARTMENT OF REVENUE

15 DEC 17 2015

C. GOLDEN

NOV 21 2016

COVER LETTER

**TO: Registration Section
Division of Corporations**

SUBJECT: FORGOTTEN COAST 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:

DAVID PIERCE

Name of Person

Firm/Company

PO BOX 99

Address

SOPCHOPPY, FL 32358

City/State and Zip Code

lbkacct@att.net

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

For further information concerning this matter, please call:

LASHELLE KEEL

850

539-5171

at ()

Name of Person

Area Code

Daytime Telephone Number

Enclosed is a check for the following amount:

Ref # W15000078730

☐

\$125.00 Filing Fee

☐

\$130.00 Filing Fee &
Certificate of Status

☐

\$155.00 Filing Fee &
Certified Copy
(additional copy is enclosed)

☐

\$160.00 Filing Fee,
Certificate of Status &
Certified Copy
(additional copy is enclosed)

Mailing Address

New Filing Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Street Address

New Filing Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, FL 32301

16 Nov 11 10:00 AM

FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS**Detail by Entity Name****Rejected Filing**

FORGOTTEN COAST EMERGENCY PHYSICIANS LLC

Filing Information

Document Number	W15000078730	
Filed Date	12/07/2015	
Expire at Usual Time	Y	
Penalty Fee	00.00	
Associated Document Number	Document Type	FL LLC
Filed By	DAVID PIERCE	

Document Images

No images are available for this filing.

RECEIVED
16 NOV 17 AM 11:20

16 NOV 17 AM 11:22



FLORIDA DEPARTMENT OF STATE
Division of Corporations

December 7, 2015

DAVID PIERCE

SUBJECT: FORGOTTEN COAST EMERGENCY PHYSICIANS LLC
Ref. Number: W15000078730

We have received your document for FORGOTTEN COAST EMERGENCY PHYSICIANS LLC and your check(s) totaling \$125.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

THE CONSENT LETTER TO RELEASE THE NAME HAS NOT BEEN SIGNED.

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) 245-6052.

Terri J Schroeder
Regulatory Specialist II

Letter Number: 615A00025558

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EFFECTIVE DATE 01/01/17

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

ARTICLE I - Name:

The name of the Limited Liability Company is:

FORGOTTEN COAST 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:

14 WINTHROP AVE
SOPCHOPPY, FL 32358

Mailing Address:

PO BOX 99
SOPCHOPPY, FL 32358

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:

LASHELLE KEEL

Name

58 SIOUX CIRCLE

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

HAVANA

FL

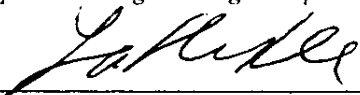
32333

City

State

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..


Registered Agent's Signature (REQUIRED)

(CONTINUED)

ARTICLE IV-

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

Title:

"AMBR" = Authorized Member

"MGR" = Manager

MGR

MGR

Name and Address:

DAVID PIERCE

PO BOX 99

SOPCHOPPY, FL 32358

KYM RITTMAN

PO BOX 99

SOPCHOPPY, FL 32358

(Use attachment if necessary)

ARTICLE V: Effective date, if other than the date of filing: 01/01/2017 (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.)

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.

ARTICLE VI: Other provisions, if any.

REQUIRED SIGNATURE:



Signature of a member or an authorized representative of a member.

This document is executed in accordance with section 605.0203 (1) (b), Florida Statutes.
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.

LASHELLE KEEL

Typed or printed name of signee

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)