

L170000038552

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐

PICK-UP

☐

WAIT

☐

MAIL

(Business Entity Name)

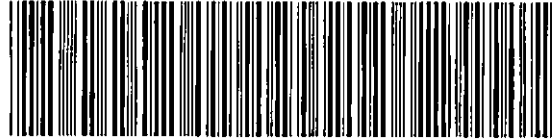
(Document Number)

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

Special Instructions to Filing Officer:

Wmills

Office Use Only



300439128793

11/05/24--01019--007 \*\*52.50

2024/10/27 - 5 PM 1:40  
Filing Office

## COVER LETTER

TO: Registration Section  
Division of Corporations

SUBJECT: INTRINSIC 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:

BEAU ROWNS  
Name of Person  
INTRINSIC MEDICAL GROUP, LLC  
Firm/Company  
3302 N 1100 W ~~PLEASANT VIEW~~  
Address  
PLEASANT VIEW, UT 84414  
City/State and Zip Code  
OFFICE@INTRINSICMEDICALGROUP.COM  
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

BEAU ROWNS at (801) 675-9626  
Name of Person Area Code Daytime Telephone Number

Enclosed is a check for the following amount:

- |                                             |                                                                        |                                                                                                  |                                                                                                                            |
|---------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> \$25.00 Filing Fee | <input type="checkbox"/> \$30.00 Filing Fee &<br>Certificate of Status | <input type="checkbox"/> \$55.00 Filing Fee &<br>Certified Copy<br>(additional copy is enclosed) | <input type="checkbox"/> \$60.00 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 Address:**

Registration Section  
Division of Corporations  
The Centre of Tallahassee  
2415 N. Monroe Street, Suite 810  
Tallahassee, FL 32303

INTRINSIC MEDICAL GROUP, LLC

**If Changing Registered Agent, Signature of New Registered Agent**

**MGR = Manager**  
**AMBR = Authorized Member**

[illegible]

[illegible]

(If an effective date is listed, the date must be specific and cannot be prior to date of filing or more than 90 days after filing.) Pursuant to 605.0207 (3)(b)

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.

Signature of a member or authorized representative of a member

Typed or printed name of signee

**Filing Fee: \$25.00**