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(Re	equestor's Name)			
(Ad	dress)			
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(Address)				
(City/State/Zip/Phone #)				
PICK-UP	☐ WAIT ☐ MAIL			
(Business Entity Name)				
(Do	ocument Number)			
Certified Copies	Certificates of Status			
Special Instructions to Filing Officer:				
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FILED

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S. WARREN NOV 1 5 2017

COVER LETTER

r o :	Registration Section Division of Corporations
jUBJE	CT: MOCESTIC MINDS THE APY LLC Name of Limited Liability Company
The end	losed Articles of Amendment and fee(s) are submitted for filing.
lease r	eturn all correspondence concerning this matter to the following:
	Clamane Daino, Psy. D. Name of Person
	Moilsing Minds Therapy LLC (Changing this Firm/Company LLC (Changing this Noval)
	13899 BISCALINE BIVA. SUITE 410
	Nowh miamy Black FL 33181 City/State and Zip Code
	E-mail address: (to be used for future annual report notification)
or furt	her information concerning this matter, please call:
	Name of Person at (914) 409-7854 Area Code Daytime Telephone Number
Enclose	ed is a check for the following amount:
□ \$25	.00 Filing Fee Solution Status

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

TOARTICLES OF ORGANIZATION **OF**

(Name of the Limited Liability Compa (A Florida Limited I	my as it now appears on our records.) Liability Company)
The Articles of Organization for this Limited Liability Company Florida document number $82 - 3268719$.	were filed on and assigned
his amendment is submitted to amend the following:	
A. If amending name, enter the new name of the limited liab	ility company here:
he new name must be distinguishable and contain the words "Limited Ciabil	ity Company the designation "LLC" or the abbreviation "L.L.C."
Enter new principal offices address, if applicable:	
Principal office address MUST BE A STREET ADDRESS)	NIA
Enter new mailing address, if applicable:	
Mailing address MAY BE A POST OFFICE BOX)	NA
3. If amending the registered agent and/or registered of registered agent and/or the new registered office address here	• •
Name of New Registered Agent:	
New Registered Office Address:	Enter Florida street address
	, Florida
New Registered Agent's Signature, if changing Registered Agent:	City Zip Code
hereby accept the appointment as registered agent and agrovisions of all statutes relative to the proper and complete accept the obligations of my position as registered agent as peing filed to merely reflect a change in the registered office company has been notified in writing of this change.	performance of my duties, and I am familiar with and provided for in Chapter 605, F.S. Or, if this document is address. I hereby confirm that the limited liability
If Chai	nging Registered Agent, Signature of New Registered Agent
Page	l of 3

Page 1 of 3

r removed from our records:

AGR = Manager

AMBR = Authorized Member

<u> </u>	<u>Name</u>	Address	Type of Action
			□ Remove
			Change
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t. Effec	ctive date, if other than the date of filing: (optional)	
(If an e <u>Note</u>	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. If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be liste ment's effective date on the Department of State's records.	0207 (3)(h) ed as the
	ecord specifies a delayed effective date, but not an effective time, at 12:01 a.m. on the earlie e 90th day after the record is filed.	er of:
Date	d November le 2017.	
	Mameria Vaino Rouito	
	Signature of a member or authorized representative of a member	.:
	6 Discourse Onesa Dallato	
	/ Glamane Oamo, Psy, D. Typed or printed name of signed	
	/ Typed or printed name of signed	
	Page 3 of 3	

Filing Fee: \$25.00

I authorize Employee Services to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Employee Services for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my

knowledge and belief.

Applicant Signature

Date

PLEASE ENCLOSE COPIES OF THE FOLLOWING DOCUMENTS FOR YOU AND YOUR CLINICAL STAFF: INSURANCE FACE SHEET, LICENSE/CERTIFICATION, DEGREE, RESUME, AND REFERENCES.

17 NOV 13 PH 2: 02