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(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

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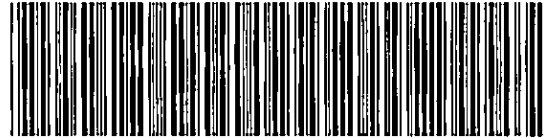
(Business Entity Name)

(Document Number)

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TALLAHASSEE, FLORIDA

S. WARREN

NOV 15 2017

COVER LETTER

TO: **Registration Section
Division of Corporations**

SUBJECT: Majestic Minds Therapy 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:

Gilamarie Daino, Psy.D.
Name of Person

Majestic Minds Therapy LLC (Changing this
Firm/Company LLC Name)
Address

13899 Biscayne Blvd. Suite 410
Address

North Miami Beach, FL 33181
City/State and Zip Code

Dr. Daino@aol.com
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Gilamarie Daino at (914) 469-7854
Name of Person Area Code Daytime Telephone Number

Enclosed is a check for the following amount:

- ☐ \$25.00 Filing Fee ☐ \$30.00 Filing Fee & Certificate of Status ☐ \$55.00 Filing Fee & Certified Copy (additional copy is enclosed) ☒ \$60.00 Filing Fee, Certificate of Status & 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

or removed from our records:

MGR = Manager

AMBR = Authorized Member

<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
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U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

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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.

Dated November 6, 2017

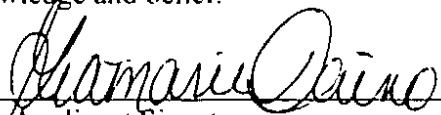
Giamane Daino, Psy.D.
Typed or printed name of signed

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FBI - LOS ANGELES

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

11/6/17

Date

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

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CLERK OF COURT
TALLAHASSEE, FLORIDA