

417 000 232006

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

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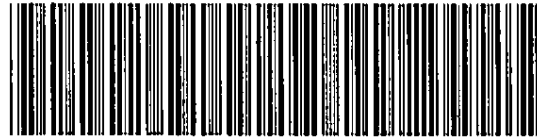
(Business Entity Name)

(Document Number)

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA
17 DEC 12 AM 7:10

COVER LETTER

TO: Registration Section
Division of Corporations

~~Subject~~ OPTIMAL CARE PEDIATRICS LLC

Name of Limited Liability Company

The enclosed Articles of Amendment and fees(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

MONIQUE MONDESIR MD.

Name of Person

OPTIMAL CARE PEDIATRICS LLC

Firm/Company

PO BOX 880364

Address

PORT ST. LUCIE, FL. 34988

City/State and Zip Code

MONIQUEMONDESIR@GMAIL.COM

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

For further information concerning this matter, please call:

MONIQUE MONDESIR MD.

215 850-8771
at ()

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

**ARTICLES OF AMENDMENT
TO
ARTICLES OF ORGANIZATION
OF**

OPTIMAL CARE PEDIATRICS LLC

(Name of the Limited Liability Company as it now appears on our records.)
(A Florida Limited Liability Company)

The Articles of Organization for this Limited Liability Company were filed on 11/9/2017 and assigned
Florida document number L17000232006.

This amendment is submitted to amend the following:

A. If amending name, enter the new name of the limited liability company here:

OPTIMAL CARE PEDIATRICS PLLC

The new name must be distinguishable and contain the words "Limited Liability Company," the designation "LLC" or the abbreviation "LLC."

Enter new principal offices address, if applicable:

(Principal office address MUST BE A STREET ADDRESS)

150 SW CHAMBER CT

STE 101

PORT ST. LUCIE, FL, 34986

Enter new mailing address, if applicable:

(Mailing address MAY BE A POST OFFICE BOX)

PO BOX 880364

PORT ST. LUCIE, FL, 34988

B. If amending the registered agent and/or registered office address on our records, enter the name of the new registered agent and/or the new registered office address here:

Name of New Registered Agent:

MONIQUE MONDESIR MD

New Registered Office Address:

150 SW CHAMBER CT STE 101

Enter Florida street address

PORT ST. LUCIE

City

Florida

Zip Code

New Registered Agent's Signature, if changing Registered Agent:

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 relative 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. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.



If Changing Registered Agent, Signature of New Registered Agent

17 DEC 12 AM 9:21
STATE OF FLORIDA
TALLAHASSEE

If amending Authorized Person(s) authorized to manage, enter the title, name, and address of each person being added or removed from our records:

MGR = Manager

AMBR = Authorized Member

<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
AMBR	MONIQUE MONDESIR MD	899 SW GRAND RESERVE BLVD	<input type="checkbox"/> Add
		PORT ST. LUCIE, FL. 34986	<input type="checkbox"/> Remove
			<input checked="" type="checkbox"/> Change
MGR	MICHAEL MILLINGTON	899 SW GRAND RESERVE BLVD	<input type="checkbox"/> Add
		PORT ST. LUCIE, FL. 34986	<input checked="" type="checkbox"/> Remove
			<input type="checkbox"/> Change
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<input type="checkbox"/> Change
			<input type="checkbox"/> Add
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			<input type="checkbox"/> Change
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<input type="checkbox"/> Change

D. If amending any other information, enter change(s) here: *(Attach additional sheets, if necessary.)*

Purpose: The practice of medicine, specifically pediatrics.

17 DEC 12 AM 7:21
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

E. Effective date, if other than the date of filing: 01/01/2018 **(optional)**

(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)

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.

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.

Dated December 5 2017



Signature of a member or authorized representative of a member

MONIQUE MONDESIR MD.

Typed or printed name of signer