

L18000170538

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐

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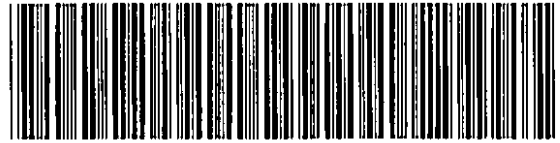
(Business Entity Name)

(Document Number)

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

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SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

## COVER LETTER

TO: Registration Section  
Division of Corporations

SUBJECT: Certified Family and Medical Marijuana  
Name of Limited Liability Company Physicians L

Dear Sir or Madam:

The enclosed Statement of Correction and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Lisa Feiler

Name of Person

Progressive Physicians Group LLC

Firm/Company

1240 N. Univ. Dr

Address

Coral Springs, FL 33071

City/State and Zip Code

drdave018@gmail.com

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

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STATE OF FLORIDA  
TALLAHASSEE, FLORIDA

For further information concerning this matter, please call:

Lisa Feiler  
Dr David Fink

Name of Person

954-778-0242  
at 954-609-9073

Area Code

Daytime Telephone Number

### STREET/COURIER ADDRESS:

Registration Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, Florida 32301

### MAILING ADDRESS:

Registration Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, Florida 32314

Enclosed is a check for the following amount:

☐ \$25 Filing Fee

☒ \$30 Filing Fee &  
Certificate of Status

☐ \$55 Filing Fee &  
Certified Copy

☐ \$60 Filing Fee,  
Certificate of Status &  
Certified Copy

**STATEMENT OF CORRECTION  
FOR  
FLORIDA OR FOREIGN LIMITED LIABILITY COMPANY**

Pursuant to section 605.0209, F.S., this document is being submitted to correct a previously filed document.

**FIRST:** The name of the limited liability company is: Certified Family & Medical Marijuana Physicians  
1240 N. Univ. Dr. Coral Springs, FL 33071

**SECOND:** The Florida Document number of the limited liability company is: L18000170538

**THIRD:** Document to be corrected is: Article of Organization LLC (copy) Attached

**(CHECK THE APPROPRIATE BOX AND COMPLETE THE APPLICABLE STATEMENT)**

☒ Contains an incorrect statement. The incorrect statement, the reason the statement is incorrect, and the corrected statement are as follows:

Physicians Group, LLC  
Progressive Physicians ~~Group~~ Correct name.  
We decided on names and the doctor made  
his choice and I input wrong name.

**OR**

☐ Was defectively signed. The manner in which the document was defectively signed and the appropriate correction are as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OR**

☐ The electronic transmission of the record was defective.

Lisa Feil 7/23/18  
Signature of Authorized Representative Date

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TALLAHASSEE, FLORIDA

Signature of new registered agent, if applicable: (NOTE: if correcting the registered agent, the new registered agent must sign accepting the designation).

**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.*

Lisa Feil  
Registered Agent's Signature

Filing Fee: \$25.00  
Certified Copy: \$30.00 (optional)