

# L19000 052 650

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(Requestor's Name)

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(Address)

\_\_\_\_\_  
(City/State/Zip/Phone #)

☐

PICK-UP

☐

WAIT

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MAIL

\_\_\_\_\_  
(Business Entity Name)

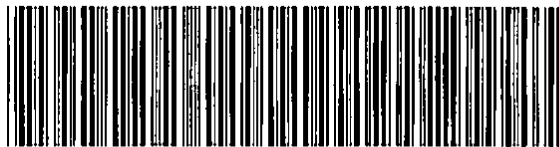
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SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

2019 OCT -7 PM 1:32

FILED

Y. SULKER

OCT 25 2019

## COVER LETTER

TO: Registration Section  
Division of Corporations

OM HEALTHCARE SOLUTIONS, LLC

SUBJECT: \_\_\_\_\_  
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:

OSBERTO DIAZ

\_\_\_\_\_  
Name of Person

OM HEALTHCARE SOLUTIONS, LLC

\_\_\_\_\_  
Firm/Company

4666 SW DACTYL ST

\_\_\_\_\_  
Address

PORT SAINT LUCIE, FL 34953

\_\_\_\_\_  
City/State and Zip Code

ODIAZ@OMMKTG.COM

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

For further information concerning this matter, please call:

OSBERTO DIAZ

305

762-0003

\_\_\_\_\_  
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

**TO  
ARTICLES OF ORGANIZATION  
OF**

OM HEALTHCARE SOLUTIONS, 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 02/22/2019 and assigned  
Florida document number L19000052650.

This amendment is submitted to amend the following:

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

OM HEALTHCARE HOLDING COMPANY, LLC

The new name must be distinguishable and contain the words "Limited Liability 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)**

4666 SW DACTYL ST

PORT SAINT LUCIE, FL 34953

**Enter new mailing address, if applicable:**

**(Mailing address MAY BE A POST OFFICE BOX)**

4666 SW DACTYL ST

PORT SAINT LUCIE, FL 34953

**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:

New Registered Office Address:

*Enter Florida street address*

Florida

City

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

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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		_____	<input type="checkbox"/> Remove
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		_____	<input type="checkbox"/> Change

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**E. Effective date, if other than the date of filing:** \_\_\_\_\_ (optional)

**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 \_\_\_\_\_, \_\_\_\_\_.

Typed or printed name of signee