

**L19000101936**

Florida Department of State  
Division of Corporations  
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To: Division of Corporations  
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**\*\*Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.\*\***

Email Address: mjshenker@szm-cpa.com

**FLORIDA LIMITED LIABILITY CO.  
JACKSONVILLE MEDICAL ALLIANCE LLC**

|                       |          |
|-----------------------|----------|
| Certificate of Status | 1        |
| Certified Copy        | 0        |
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19 APR 22 14 9:07  
JACKSONVILLE, FLORIDA  
SECRETARY OF STATE

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**ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY****ARTICLE I - Name:**

The name of the Limited Liability Company is:

**JACKSONVILLE MEDICAL ALLIANCE LLC**

(Must end with the words "Limited Liability Company, "L.L.C.," or "LLC.")

**ARTICLE II - Address:**

The mailing address and street address of the principal office of the Limited Liability Company is:

**Principal Office Address:****Mailing Address:****2729 STATE ROAD 580  
CLEARWATER, FL 33761****2729 STATE ROAD 580  
CLEARWATER, FL 33761****ARTICLE III - Registered Agent, Registered Office, & Registered Agent's Signature:**

(The Limited Liability Company cannot serve as its own Registered Agent. You must designate an individual or another business entity with an active Florida registration.)

The name and the Florida street address of the registered agent are:

**ILIANA MAZE**

Name

**2729 STATE ROAD 580**Florida street address (P.O. Box NOT acceptable)**CLEARWATER****FL 33761**

City

Zip

Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, 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 relating 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.

Registered Agent's Signature (REQUIRED)

ILIANA MAZE

(CONTINUED)

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**ARTICLE IV-**

The name and address of each person authorized to manage and control the Limited Liability Company:

**Title:**

"AMBR" = Authorized Member

"MGR" = Manager

AMBR

**Name and Address:**

MEDICAL UNITED LLC

2729 STATE ROAD 580

CLEARWATER, FL 33761

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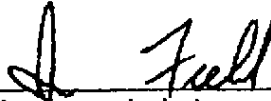
(Use attachment if necessary)

**ARTICLE V:** Effective date, if other than the date of filing: \_\_\_\_\_ (OPTIONAL)  
(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**ARTICLE VI:** Other provisions, if any.

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

**REQUIRED SIGNATURE:**



Signature of a member or an authorized representative of a member.  
(In accordance with section 605.0203 (1) (b), Florida Statutes, the execution of this document constitutes an affirmation under the penalties of perjury that the facts stated herein are true. I am aware that any false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.)

IVAN FIELD SIGNING ON BEHALF OF MEDICAL UNITED LLC

Typed or printed name of signer

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