L19 000 120 973

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer:

Office Use Only

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10/01/20--01011--004 **35.00

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TALLAHASSEE, FL

11/9/20

COVER LETTER

TO: **Registration Section**
Division of Corporations

SUBJECT: MWD LOGISTICS 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:

MICHAEL DRAVO
Name of Person

Firm/Company

42 SANDERSON DR
Address

ST JOHNS, FL 32259
City/State and Zip Code

MDRAVO@GMAIL.COM
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

MICHAEL DRAVO at (904) 386-3457
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 Address:
Registration Section
Division of Corporations
The Centre of Tallahassee
2415 N. Monroe Street, Suite 810
Tallahassee, FL 32303

ARTICLES OF AMENDMENT
TO
ARTICLES OF ORGANIZATION
OF

MWD LOGISTICS 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 05/03/2019 and assigned Florida document number L19000120973.

This amendment is submitted to amend the following:

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

MWDL-DSP 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)

Enter new mailing address, if applicable:
(Mailing address MAY BE A POST OFFICE BOX)

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TALLAHASSEE, FL

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

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

Title	Name	Address	Type of Action
_____	_____	_____	☐Add
		_____	☐Remove
		_____	☐Change
_____	_____	_____	☐Add
		_____	☐Remove
		_____	☐Change
_____	_____	_____	☐Add
		_____	☐Remove
		_____	☐Change
_____	_____	_____	☐Add
		_____	☐Remove
		_____	☐Change
_____	_____	_____	☐Add
		_____	☐Remove
		_____	☐Change

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TALLAHASSEE, FL

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

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

FILED

E. Effective date, if other than the date of filing: _____ **(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 SEPTEMBER 15, 2020.

Signature of a member or authorized representative of a member

MICHAEL DRAVO

Typed or printed name of signee

Filing Fee: $25.00

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: MWD LOGISTICS LLC

Date Program Implemented: 6/26/19

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- ☑ Job applicant
- ☑ Reasonable suspicion
- ☐ Routine fitness for duty
- ☐ Follow-up testing to Employee Assistance Program

Notice of Employer's Drug Testing Policy:

- ☑ Copy to all employees prior to testing
- ☑ Posted on employer's premises
- ☑ Copy to job applicants prior to testing
- ☐ General notice given 60 days prior to testing
- ☑ Show notice of drug testing on vacancy announcements
- ☑ Copies available in personnel office or other suitable locations
- ☐ No notice required because the employer had a drug testing program in place prior to July 1, 1990

Education:

- ☑ Resource file on providers
- ☐ Employee Assistance Program
- ☐ Education

Name of Medical Review Officer: Dr. Grady Phillips

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: Any Lab Test Now

B. Phone No.: ( ) (904) 717-6268

C. Address: 9965 San Jose Blvd Ste 30 Jacksonville, FL 32257

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and that the facts stated in it are true.

MWD Logistics	9/25/20	[signature]
Employer Name	Date	Officer/Owner Signature*

OWNER
Title

*Application must be signed by an officer or owner.

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: MWD LOGISITICS LLC

Name of Contact Person: Michael David Telephone #: _____

Policy #: 520-59779 Effective Date of Policy: 11/29/2020

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

1) Written safety policy and safety rules
2) Safety inspections
3) Preventive maintenance
4) Safety training
5) First aid
6) Accident investigation
7) Necessary record keeping

I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Certification of Employer Workplace Safety Program Premium Credit, and that the facts stated in it are true.

MWD Logistics — Employer Name

9/25/20 — Date

Officer/Owner Signature*

OWNER — Title

* Application must be signed by an officer or owner.