

L19 000121433

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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PICK-UP

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WAIT

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MAIL

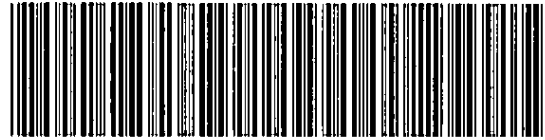
(Business Entity Name)

(Document Number)

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JUL 03 2019

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2019 JUN 20 AM 8:39  
SECRETARY OF STATE  
TALLAHASSEE, FL

## COVER LETTER

**TO: Registration Section  
Division of Corporations**

**SUBJECT:** 1ST NURSING CARE SERVICES, 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:

CLARA MONFORT

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

1ST NURSING CARE SERVICES, LLC

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

10335 SW 50TH CT

\_\_\_\_\_  
Address

COOPER CITY, FL 33328

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

1STNURSINGCARESERVICES@GMAIL.COM

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

For further information concerning this matter, please call:

CLARA MONFORT

786 451-1483  
at ( )  
Area Code Daytime Telephone Number

Enclosed is a check for the following amount:

- |  |  |  |  |
|--|--|--|--|
| <input checked="" type="checkbox"/> \$25.00 Filing Fee | <input type="checkbox"/> \$30.00 Filing Fee &<br>Certificate of Status | <input type="checkbox"/> \$55.00 Filing Fee &<br>Certified Copy<br>(additional copy is enclosed) | <input type="checkbox"/> \$60.00 Filing Fee,<br>Certificate of Status &<br>Certified Copy<br>(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



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>
MGR	CLARA MONFORT	10335 SW 50TH CT COOPER CITY, FL 33328	<input checked="" type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<input type="checkbox"/> Change
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
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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 \_\_\_\_\_, \_\_\_\_\_

Signature of a member or authorized representative of a member

Typed or printed name of signee