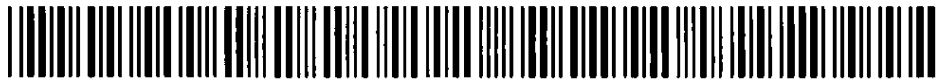


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Florida Department of State
Division of Corporations
Electronic Filing Cover Sheet

Note: Please print this page and use it as a cover sheet. Type the fax audit number (shown below) on the top and bottom of all pages of the document.

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To:

Division of Corporations
Fax Number : (850) 617-6381

From:

Account Name : FOLEY & LARDNER
Account Number : I19980000047
Phone : (407) 423-7656
Fax Number : (407) 648-1743

****Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.****

Email Address: LHunt@foley.com

**FLORIDA LIMITED LIABILITY CO.
PARETO POPULATION HEALTH MANAGEMENT
PRACTICE, PLLC**

Certificate of Status	1
Certified Copy	1
Page Count	03
Estimated Charge	\$160.00

Please Back Date to Orig. Fax Date

10/3/19

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October 7, 2019

FLORIDA DEPARTMENT OF STATE
Division of Corporations

FOLEY & LARDNER

SUBJECT: PARETO POPULATION HEALTH MANAGEMENT PRACTICE, PLLC
REF: W19000089025

We received your electronically transmitted document. However, the document has not been filed. Please make the following corrections and refax the complete document, including the electronic filing cover sheet.

The document is illegible and not acceptable for imaging.

An individual must sign on behalf of the business entity you have designated as the registered agent.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6050.

Susan Tallent
Regulatory Specialist II

FAX Aud. #: H19000293748
Letter Number: 619A00020562

((H19000293748 3)))

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

ARTICLE I - Name:

The name of the Limited Liability Company is:

PARETO POPULATION HEALTH MANAGEMENT PRACTICE, PLLC

(Must contain 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:

1697 Kings Road

Jacksonville, FL 32209

Mailing Address:

3421 Victoria Lakes Drive North

Jacksonville, FL 32226

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:

C T Corporation System

Name

1200 South Pine Island Road

Florida street address (P.O. Box **NOT** acceptable)

Plantation,

Florida

33324

City

State

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.

C T Corporation System

By: 

Registered Agent's Signature (REQUIRED)

Ann J. Williams, Assistant Vice President

(CONTINUED)

((H19000293748 3)))

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19 OCT -3 AM 10:57
JACKSONVILLE, FLORIDA

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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:

Kenyatta Lee, M.D.

(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.)

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.

ARTICLE VI: Other provisions, if any.

The professional purpose is the operation of a medical practice.

REQUIRED SIGNATURE

Kenyatta Lee MD

Signature of a member or an authorized representative of a member.

This document is executed in accordance with section 605.0203 (1) (b), Florida Statutes.
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.

Kenyatta Lee, M.D.

Typed or printed name of signee

Filing Fees:

\$125.00 Filing Fee for Articles of Organization and Designation of Registered Agent

\$ 30.00 Certified Copy (Optional)

\$ 5.00 Certificate of Status (Optional)

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