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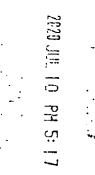
|                             |                 | _         |
|-----------------------------|-----------------|-----------|
| (Requ                       | estor's Name)   |           |
|                             |                 |           |
| (Addr                       | ess)            |           |
|                             |                 |           |
| (Addr                       | ess)            |           |
|                             |                 |           |
| (City/                      | State/Zip/Phone | #)        |
|                             |                 |           |
| PICK-UP                     | WAIT            | MAIL      |
|                             |                 |           |
| (Busin                      | ness Entity Nam | e)        |
|                             |                 |           |
| (Docu                       | ıment Number)   |           |
|                             |                 |           |
| Certified Copies            | Certificates    | of Status |
|                             |                 |           |
|                             |                 | 7         |
| Special Instructions to Fil | ling Officer:   |           |
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Office Use Only



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AUG 21 2020 S. YOUNG

## **COVER LETTER**

| то:       | Registration Se<br>Division of Cor |                                              |                                                                     |                                                                                            |
|-----------|------------------------------------|----------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| SUBJE     | Shadow Tra                         | ailers, LLC                                  |                                                                     |                                                                                            |
| SUBJE     | C1:                                | Name of Lim                                  | ited Liability Company                                              | - · ·                                                                                      |
| The encl  | losed Articles of                  | Amendment and fee(s) are sub                 | mitted for filing.                                                  |                                                                                            |
| Please re | cturn all correspo                 | ondence concerning this matter               | to the following:                                                   |                                                                                            |
|           |                                    | Tommy D. Permenter, Jr.,                     | Esquire                                                             |                                                                                            |
|           |                                    |                                              | Name of Person                                                      |                                                                                            |
|           |                                    | The Permenter Law Firm,                      | P.A.                                                                |                                                                                            |
|           |                                    |                                              | Firm/Company                                                        |                                                                                            |
|           |                                    | 2201 S.E. 30th Avenue, Su                    | ite 202                                                             |                                                                                            |
|           |                                    |                                              | Address                                                             |                                                                                            |
|           |                                    | Ocala, Florida 34471                         |                                                                     |                                                                                            |
|           |                                    | Tommy@Permenterlaw.cor                       | City/State and Zip Code                                             |                                                                                            |
|           |                                    |                                              | to be used for future annual report notif                           | ication)                                                                                   |
| For furth | her information co                 | oncerning this matter, please ca             | all:                                                                |                                                                                            |
| Tommy     | D. Permenter, Jr                   | ., Esquire                                   | 352 622-1811<br>at ( )                                              |                                                                                            |
|           | Name of                            | f Person                                     | Area Code Daytimo                                                   | e Telephone Number                                                                         |
| Enclosed  | d is a check for th                | ne 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 Addres Registration S      |                                              | Street Address:<br>Registration Sec                                 | etion                                                                                      |

Registration Section Division of Corporations P.O. Box 6327 Tallahassee, FL 32314

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

| Shadow Trailers, LLC                                |                                                                                 |                      | 3                          |
|-----------------------------------------------------|---------------------------------------------------------------------------------|----------------------|----------------------------|
| (Name of the Lim                                    | ited Liability Company as it now appea<br>(A Florida Limited Liability Company) | irs on our records.) |                            |
|                                                     | (Tribinal Shaked Shability Company)                                             |                      | (= ','                     |
| The Articles of Organization for this Limited I     | Liability Company were filed on $\frac{M}{2}$                                   | larch 13, 2020       | and assigned               |
| lorida document number L20000089552                 |                                                                                 |                      | P                          |
|                                                     |                                                                                 |                      | (N                         |
| his amendment is submitted to amend the fol         | lowing:                                                                         |                      | $\vec{\Box}$               |
| a. If amending name, enter the new name o           | of the limited liability company h                                              | ere:                 |                            |
| <u> </u>                                            |                                                                                 |                      |                            |
| he new name must be distinguishable and contain the | words "I imited I ishility Commons " the                                        | designation "LLC" or | etho abbreviation "L. C."  |
| he new name must be distinguishable and contain the | words Limited Liability Company, the                                            | designation LLC of   | the aboreviation L.E.C.    |
| nter new principal offices address, if appli        | cable:                                                                          |                      | <u></u>                    |
| Principal office address MUST BE A STRE             | ET ADDRESS)                                                                     |                      |                            |
|                                                     |                                                                                 |                      |                            |
|                                                     | <del></del>                                                                     |                      |                            |
|                                                     |                                                                                 |                      |                            |
| nter new mailing address, if applicable:            |                                                                                 |                      |                            |
| Mailing address MAY BE A POST OFFICE                | <u></u>                                                                         |                      |                            |
|                                                     |                                                                                 |                      |                            |
|                                                     |                                                                                 |                      |                            |
| . If amending the registered agent and/or           | registered office address on our                                                | records, enter the   | e name of the new register |
| gent and/or the new registered office addre         |                                                                                 |                      |                            |
|                                                     |                                                                                 |                      |                            |
| Name of New Registered Agent:                       | Debra L. Brindley                                                               |                      |                            |
| Name of New Registered Algeria.                     |                                                                                 |                      |                            |
| New Registered Office Address:                      | 1720 S.W. 67th Avenue                                                           |                      |                            |
|                                                     | Enter Flo                                                                       | orida street address |                            |
|                                                     | Plantation                                                                      | , Floric             | da <u>33317</u>            |
|                                                     | 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.

Is 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

| <u>Title</u> | <u>Name</u>       | <u>Address</u>            | Type of Action |
|--------------|-------------------|---------------------------|----------------|
| MGR          | Larry R. Pruitt   | 11860 N.W. 160th Avenue   | □ Add          |
|              |                   | Morriston, Florida 32668  | Nremove        |
|              |                   |                           | □Change        |
| MGR          | Debra L. Brindley | 1720 S.W. 67th Avenue     |                |
|              |                   | Plantation, Florida 33317 | □Remove        |
|              |                   |                           | Change         |
|              |                   |                           | □ Add          |
|              |                   |                           | Remove         |
|              |                   |                           | □Change        |
|              |                   |                           | □Add           |
|              |                   |                           | □Remove        |
|              |                   |                           | Change         |
|              |                   |                           |                |
|              |                   |                           | □Remove        |
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|              |                   |                           | Remove         |
|              |                   |                           | □Change        |

| fective date, if other than the date of filing:  (optional)  (opti |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| Sective date, if other than the date of filing:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| fective date, if other than the date of filing:  of effective date, if other than the date of filing:  of 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 605.020.  The first if the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as cument's effective date on the Department of State's records.  State of the filed.  Led June  State of a member of authorized repossentative of a member.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | _     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| rective date, if other than the date of filing:  optional)  n 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 605.020.  12. If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as sument's effective date on the Department of State's records.  12. On the earlier of: (b) The 90th day after the is filed.  13. On the earlier of: (b) The 90th day after the is filed.  14. On the state of a member of a number of a member of a member.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| Signature of a member or authorized representative of a member  [coctive date, if other than the date of filing:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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