

L20000116843

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP WAIT MAIL

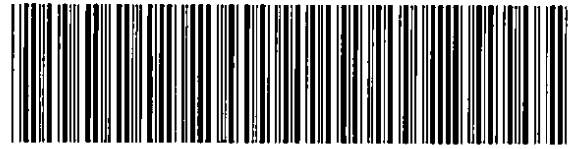
(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

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08/08/23--01010--020 **30.00

2023 AUG 8 PM 1:57
STATE
TALLAHASSEE, FL

08/08/23

R. HUNT

08/08/23

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: JUAN JOSE CRUZ 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:

AMADA FELIZ
Name of Person

AZOY TAX
Firm/Company

4901 NW 17TH WAY SUITE 306
Address

FORT LAUDERDALE, FL 33309
City/State and Zip Code

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

RECEIVED
STATE
TALLAHASSEE, FL
JUN 11 2008 8 PM 1:57

For further information concerning this matter, please call:

AMADA FELIZ at (954) 229-1652
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

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>
_____	_____	_____	<input type="checkbox"/> Add
_____	_____	_____	<input type="checkbox"/> Remove
_____	_____	_____	<input type="checkbox"/> Change
_____	_____	_____	<input type="checkbox"/> Add
_____	_____	_____	<input type="checkbox"/> Remove
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_____	_____	_____	<input type="checkbox"/> Change

STATE
PHYSICIAN
ASSOCIATION
FLORIDA

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

Multiple horizontal lines for amending information.

2023 AUG 13 PM 1:57
STATE COMMISSIONER, FL

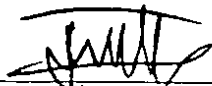
E. Effective date, if other than the date of filing: _____ (optional)

(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 8/1/2023



Signature of a member or authorized representative of a member

JUAN J CRUZ

Typed or printed name of signee

Filing Fee: \$25.00