

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: PALM CITY MEDICAL GROUP LLC
(Name of Limited Liability Company)

The enclosed member, resignation or dissociation and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to:

SIMONA SILVESTRI
(Contact Person)

PALM CITY MEDICAL GROUP LLC
(Firm/Company)

2846 SW TOWN CENTER WAY
(Address)

PALM CITY FL 34990
(City/State and Zip Code)

For further information concerning this matter, please call:

SIMONA SILVESTRI at (305) 807-0086
(Name of Contact Person) (Area Code & Daytime Telephone Number)

Enclosed please find a check made payable to the Florida Department of State for:
 \$25 Filing Fee \$55 Filing Fee & Certified Copy

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

CR21079 (2/14)

FILED
2023 NOV 27 PM 2:12
TALLAHASSEE, FL



FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS

**DISSOCIATION OR RESIGNATION OF MEMBER, MANAGER FROM
FLORIDA OR FOREIGN LIMITED LIABILITY COMPANY**
(Pursuant to 605.0216, Florida Statutes)

1. The name of the limited liability company as it appears on the records of the Florida Department
of State is: PALM CITY MEDICAL GROUP

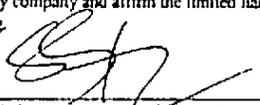
2. The Florida document/registration number assigned to this limited liability company is:
L21000504620

3. The date this member/manager withdrew/resigned or will withdraw/resign is: 11/12/2023

4. I, SIMONA SILVESTRI, hereby withdraw/resign as a
(Print Name of Person Resigning)

MEMBER
(Print Title)

of this limited liability company and affirm the limited liability company has been notified of my
resignation in writing.



Signature of Dissociating Member or Resigning Manager

Filing Fee: \$25.00 (Required)
Certified Copy: \$30.00 (Optional)

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STATE OF FLORIDA
TALLAHASSEE, FL

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