

123000126762

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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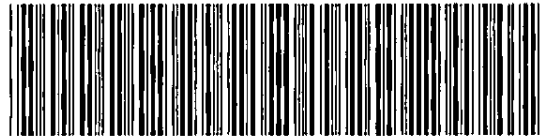
(Business Entity Name)

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## COVER LETTER

**TO: Registration Section,  
Division of Corporations**

**SUBJECT: BROWARD MEDICAL CONSULTANTS 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:

LAWRENCE KOPYLOV

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

BROWARD MEDICAL CONSULTANTS LLC

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

1920 E HALLANDALE BEACH BLVD STE 901

\_\_\_\_\_  
Address

HALLANDALE BEACH, FL 33009

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

yourfamilyeyecare@gmail.com

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

For further information concerning this matter, please call:

LAWRENCE KOPYLOV

718

660-7456

at (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
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

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**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 NOVEMBER 7TH 2023

Typed or printed name of signee

**Filing Fee: \$25.00**