

U230000205310

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

(Business Entity Name)

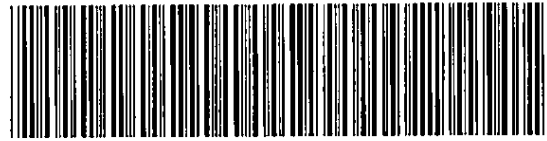
(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

Special Instructions to Filing Officer:

U23000059293

Office Use Only



200405620822

2  
4/26/24

FILED  
2023 APR 21 AM 9:02  
SECRETARY OF STATE  
TALLAHASSEE, FL  
2023 APR 21 PM 3:51  
RECEIVED  
OFFICE OF THE CLERK  
TALLAHASSEE, FL



FLORIDA DEPARTMENT OF STATE  
Division of Corporations

April 24, 2023

CT CORP

**CORRECTED**  
**Please Allow For**  
**Same File Date**

SUBJECT: CHRONIUS CARE MEDICAL GROUP PLLC  
Ref. Number: W23000059293

We have received your document for CHRONIUS CARE MEDICAL GROUP PLLC. However, the document has not been filed and is being returned for the following:

The specific purpose of the entity must be set forth in the document.

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) 245-6052.

Karen Lovelace  
Regulatory Specialist II

Letter Number: 023A00009

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2023 APR 26 AM 9:50

FLORIDA DEPARTMENT OF STATE  
TALLAHASSEE, FLORIDA

# CT CORP

3458 Lakeshore Drive, Tallahassee, FL 32312  
850-656-4724

Date: 04/21/2023

Acc#I20160000072

*en: c DW*

|             |                                  |
|-------------|----------------------------------|
| Name:       | Chronius Care Medical Group PLLC |
| Document #: |                                  |
| Order #:    | 14898764 - 1                     |

|                                   |                          |                         |  |
|-----------------------------------|--------------------------|-------------------------|--|
| Certified Copy of Arts & Amend:   | <input type="checkbox"/> |                         |  |
| Plain Copy:                       | <input type="checkbox"/> |                         |  |
| Certificate of Good Standing:     | <input type="checkbox"/> |                         |  |
| Certified Copy of                 | <input type="checkbox"/> |                         |  |
| Apostille/Notarial Certification: | <input type="checkbox"/> | Country of Destination: |  |
|                                   |                          | Number of Certs:        |  |

|   |  |
|---|--|
| Filing: <input checked="" type="checkbox"/> | Certified: <input checked="" type="checkbox"/> |
|   | Plain: <input type="checkbox"/>                |
|   | COGS: <input type="checkbox"/>                 |

Email Address for Annual Report Notifications:

pzanayed@mwe.com

|                     |
|---------------------|
| Availability _____  |
| Document _____      |
| Examiner _____      |
| Updater _____       |
| Verifier _____      |
| W.P. Verifier _____ |
| Ref# _____          |

Amount: \$ 155.00

Thank you!

COVER LETTER

TO: New Filing Section  
Division of Corporations

SUBJECT: Chronius Care Medical Group PLLC  
Name of Limited Liability Company

The enclosed Articles of Organization and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Patrick T. Zanayed

Name of Person

McDermott Will & Emery LLP

Firm/Company

444 West Lake Street, Suite 4000

Address

Chicago, IL 60606-0029

City/State and Zip Code

pzanayed@mwe.com

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

For further information concerning this matter, please call:

Betty Brito

305

347-6538

at ( )

Name of Person

Area Code

Daytime Telephone Number

Enclosed is a check for the following amount:

☒ \$125.00 Filing Fee

☐ \$130.00 Filing Fee &  
Certificate of Status

☐ \$155.00 Filing Fee &  
Certified Copy  
(additional copy is enclosed)

☐ \$160.00 Filing Fee,  
Certificate of Status &  
Certified Copy  
(additional copy is enclosed)

Mailing Address

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

Street Address

New Filing Section Division  
The Centre of Tallahassee  
2415 N. Monroe Street, Suite 810  
Tallahassee, FL 32303

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SECRETARY OF STATE  
TALLAHASSEE, FL

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

ARTICLE I - Name:

The name of the Limited Liability Company is:

Chronius Care Medical Group 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:

7901 4th ST Suite 14102

St. Petersburg, FL 33702

Mailing Address:

7901 4th ST Suite 14102

St. Petersburg, FL 33702

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:

NORTHWEST REGISTERED AGENT, INC

Name

7901 4TH STREET, SUITE 300

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

St. Petersburg

FL

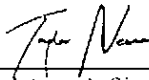
33702

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.*



Registered Agent's Signature (REQUIRED)

(CONTINUED)

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TALLAHASSEE, FL

**ARTICLE IV-**

The name and address of each person authorized to manage and control the Limited Liability Company:

**Title:**

"AMBR" = Authorized Member

"MGR" = Manager

**Name and Address:**

MGR

Karim Hanna  
7901 4th ST Suite 14102 Street  
St. Petersburg, FL 33702

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Use attachment if necessary)

**ARTICLE V:** Effective date, if other than the date of filing: N/A (OPTIONAL)

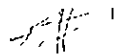
(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**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.

Professional Medical Services

**REQUIRED SIGNATURE:**



**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.

Karim Hanna

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)

**FILED**  
**2023 APR 21 AM 9:03**  
**SECRETARY OF STATE**  
**TALLAHASSEE, FL**