

L24000070537

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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PICK-UP

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MAIL

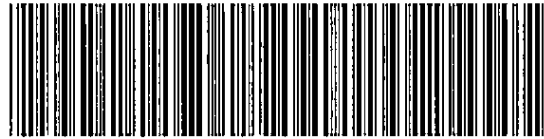
(Business Entity Name)

(Document Number)

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

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TALLAHASSEE, FL

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TALLAHASSEE, FLORIDA

125

**CORPORATE  
ACCESS,  
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**WALK IN**

**PICK UP:** BROOK 2/9

**CERTIFIED COPY**

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LLC

1. **VIRTUAL HEALTH PHYSICIAN SERVICES, PLLC**

(CORPORATE NAME AND DOCUMENT #)

2.

(CORPORATE NAME AND DOCUMENT #)

3.

(CORPORATE NAME AND DOCUMENT #)

4.

(CORPORATE NAME AND DOCUMENT #)

5.

(CORPORATE NAME AND DOCUMENT #)

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(CORPORATE NAME AND DOCUMENT #)

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TALLAHASSEE, FL

**SPECIAL  
INSTRUCTIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COVER LETTER**

**TO: New Filing Section  
Division of Corporations**

**SUBJECT:** Virtual Health Physician Services, LLC  
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:

Jacob Williams

Name of Person

Fairchild Record Search, Ltd.

Firm/Company

3400 Capitol Blvd SE, Ste 101

Address

Tumwater, WA 98501

City/State and Zip Code

dzafar@tstelemed.com

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

For further information concerning this matter, please call:

Jacob Williams

at ( 360 )

786-8775

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 of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

SECRETARY OF STATE  
TALLAHASSEE, FL

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**ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY**

**ARTICLE I - Name:**

The name of the Limited Liability Company is:

Virtual Health Physician Services, 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:**

11215 Metro Parkway

Building 3, Suite 1

Fort Myers, FL 33966

**Mailing Address:**

PO Box 60159

Fort Myers, FL 33906

**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:

Daryoush Zafar

Name

11215 Metro Parkway, Building 3, Suite 1

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

Fort Myers

FL

33966

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..*

DocuSigned by:

Daryoush Zafar

ABA158B91043452

Registered Agent's Signature (REQUIRED)

(CONTINUED)

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**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

Mohammed Zaman, M.D.  
9110 College Pointe Court  
Fort Myers, FL 33919

(Use attachment if necessary)

**ARTICLE V:** Effective date, if other than the date of filing: \_\_\_\_\_ (OPTIONAL)

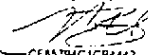
(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**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.

The purpose of this professional limited liability company is to engage in the practice of medicine and to do any and all things necessary, convenient, or incidental to that purpose.

**REQUIRED SIGNATURE:**

DocuSigned by:  
  
CF85794C1CB4442

**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.

Mohammed Zaman

Typed or printed name of signer

**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)

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TALLAHASSEE, FL

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