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(Address)

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(City/State/Zip/Phone #)

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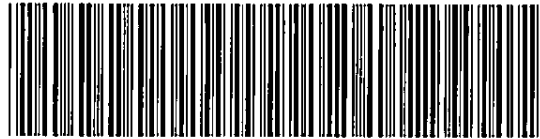
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R. HUNT  
C5/22/24

## COVER LETTER

**TO: Registration Section  
Division of Corporations**

**SUBJECT:** Albi Medical Center 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:

Odisa Gonzalez

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

Odisa Gonzalez CPA PA

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

6251 NW 110th Terrace

\_\_\_\_\_  
Address

Hialeah, FL 33012

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

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

For further information concerning this matter, please call:

Odisa Gonzalez

305 332-7118

at ( )

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

Area Code

Daytime Telephone Number

Enclosed is a check for the following amount:

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|--|--|--|--|
| <input checked="" type="checkbox"/> \$25.00 Filing Fee | <input type="checkbox"/> \$30.00 Filing Fee &<br>Certificate of Status | <input type="checkbox"/> \$55.00 Filing Fee &<br>Certified Copy<br>(additional copy is enclosed) | <input type="checkbox"/> \$60.00 Filing Fee,<br>Certificate of Status &<br>Certified Copy<br>(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 Changing Registered Agent, Signature of New Registered Agent**

**MGR = Manager**  
**AMBR = Authorized Member**

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

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**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)

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Dated May 10th 2024



Signature of a member or authorized representative of a member

**Maikel Albi**

Typed or printed name of signee

**Filing Fee: \$25.00**