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To:

Division of Corporations

Fax Number : (850) 617-6383

From:

Account Name : C T CORPORATION SYSTEM

Account Number : FCA000000023 Phone : (850)205-8842

Fax Number : (850) 878-5368

## LLC DISSOLUTION OR WITHDRAWAL PKY 1300 RIVERPLACE, LLC

| Certificate of Status | 0       |
|-----------------------|---------|
| Certified Copy        | 0       |
| Page Count            | 03      |
| Estimated Charge      | \$25,00 |

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Electronic Filing Menu

Corporate Filing Menu

Help

D. BRUCE SEP 3 0 2016

## **COVER LETTER**

| TO: Registration Division of                             | n Section<br>Corporations                    |                                       |                                                                                             |          |                  |
|----------------------------------------------------------|----------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------|----------|------------------|
| PKY SUBJECT:                                             | 300 Riverplace, LLC                          |                                       |                                                                                             |          |                  |
|                                                          | (Name of Fo                                  | reign Limited Liability               | Company)                                                                                    |          |                  |
| Dear Sir or Madani:                                      |                                              |                                       |                                                                                             |          |                  |
| The enclosed withdr                                      | rawal and fec(s) are submitte                | d for filing.                         |                                                                                             |          |                  |
| Please return all cor                                    | respondence concerning this                  | matter to the following               | g:                                                                                          |          |                  |
| Jeremy Darsett                                           |                                              |                                       |                                                                                             |          |                  |
|                                                          | (Name of Person)                             |                                       | _                                                                                           |          |                  |
| Parkway Properties                                       | , Inc.                                       |                                       |                                                                                             |          |                  |
|                                                          | (Firm Company)                               |                                       | _                                                                                           |          |                  |
| 390 North Orange /                                       | Avenue, Suite 2400                           |                                       |                                                                                             |          |                  |
|                                                          | (Address)                                    |                                       | _                                                                                           |          |                  |
| Orlando, FL 32801                                        |                                              |                                       |                                                                                             |          |                  |
|                                                          | (City/State and Zip Cod                      | lc)                                   |                                                                                             |          |                  |
| For further informat                                     | ion concerning this matter, p                | lease call:                           |                                                                                             | SEP 2    | No. of Section 1 |
| Jeremy Dorsett                                           |                                              | 407<br>at (                           | 650-0593                                                                                    |          |                  |
| (N                                                       | ame of Person)                               | (Area Code &                          | & Daytime Telephone                                                                         | O 77     |                  |
| Registration<br>Division of<br>Clifton Bui<br>2661 Exect | Corporations                                 | Regis<br>Divis<br>P.O. I              | LING ADDRESS:<br>stration Section<br>ion of Corporations<br>Box 6327<br>hassee, Florida 323 | 10A      |                  |
| Enclosed is a check                                      | for the following amount:                    |                                       |                                                                                             |          |                  |
| ☐ \$25 Filing Fee                                        | ☐ \$30 Filing Fee &<br>Certificate of Status | □ \$55 Filing Fee &<br>Certified Copy | ☐ \$60 Filing Fe<br>Certificate of<br>Certified Cop                                         | Status & |                  |

## NOTICE OF WITHDRAWAL OF CERTIFICATE OF AUTHORITY

| PKY 1300 R   | iverplace, LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|              | (Name of limited liability company)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         | <del></del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| <del></del>  | (Jurisdiction of its organization)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|              | (Date registered with Florida Department of State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|              | (Florida Document Number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | <del></del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| This limited | d liability company is withdrawing its certificate of authority in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | this state.                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|              | (Signature of authorized representative)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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Filing Fee: \$25.00