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(Requestor's Name)

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(Address)

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(Address)

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(City/State/Zip/Phone #)

PICK-UP     WAIT     MAIL

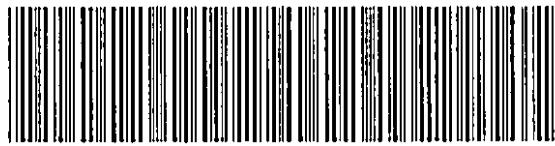
\_\_\_\_\_  
(Business Entity Name)

\_\_\_\_\_  
(Document Number)

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**CT CORP**  
**3458 Lakeshore Drive, Tallahassee, FL 32312**  
**850-656-4724**

**Date:** 5/18/2020

Acc#I20160000072

*en: c DPH*

Name:	TRINITY MEDICAL PHYSICIAN SERVICES, LLC
Document #:	
Order #:	12993768 - 1

Certified Copy of Arts & Amend:	<input type="checkbox"/>		
Plain Copy:	<input type="checkbox"/>		
Certificate of Good Standing:	<input type="checkbox"/>		
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Apostille/Notarial Certification:	<input type="checkbox"/>	Country of Destination:	
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Verifier _____
W.P. Verifier _____
Ref# _____

Amount: \$ **155.00**

**Thank you!**

**APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY FOR AUTHORIZATION TO TRANSACT BUSINESS  
IN FLORIDA**

*IN COMPLIANCE WITH SECTION 605.0902, FLORIDA STATUTES, THE FOLLOWING IS SUBMITTED TO REGISTER A FOREIGN LIMITED LIABILITY COMPANY TO TRANSACT BUSINESS IN THE STATE OF FLORIDA:*

1. Trinity Medical Physician Services, LLC

(Name of Foreign Limited Liability Company; must include "Limited Liability Company," "L.L.C.," or "LLC.")

(If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida. The alternate name must include "Limited Liability Company," "L.L.C.," or "LLC.")

2. Delaware

85-0888022

2. (Jurisdiction under the law of which foreign limited liability company is organized)

3. (FEI number, if applicable)

4.

(Date first transacted business in Florida, if prior to registration.)  
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)

5. 44 S. Broadway, 1st Floor

5. (Street Address of Principal Office)

6. 44 S. Broadway, 1st Floor

6. (Mailing Address)

White Plains, New York 10601

White Plains, New York 10601

7. Name and street address of Florida registered agent: (P.O. Box NOT acceptable)

Name: CT Corporation System

Office Address: 1200 South Pine Island Road

Plantation

(City)

33324

, Florida

(Zip code)

Registered agent's acceptance:

*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 application, 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 relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.*

Kathleen A. Gabble, Asst. Secretary  
(Registered agent's signature)

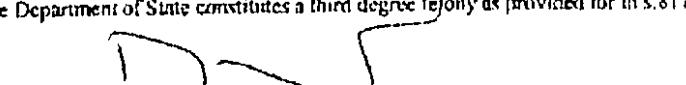
8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage [up to six (6) total]:

<u>Title or Capacity:</u>	<u>Name and Address:</u>	<u>Title or Capacity:</u>	<u>Name and Address:</u>
<input type="checkbox"/> Manager	Name: <u>Trinity Medical Acquisition, LLC</u>	<input type="checkbox"/> Manager	Name: <u>Richard Shinto</u>
<input checked="" type="checkbox"/> Member	Address: <u>44 S. Broadway, 1st Floor</u>	<input type="checkbox"/> Member	Address: <u>44 S. Broadway, 1st Floor</u>
<input type="checkbox"/> Authorized	<u>White Plains, NY 10601</u>	<input type="checkbox"/> Authorized	<u>White Plains, NY 10601</u>
Person		Person	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Manager	Name: <u>Douglas Malton</u>	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: <u>44 S. Broadway, 1st Floor</u>	<input type="checkbox"/> Member	Address: _____
<input checked="" type="checkbox"/> Authorized	<u>White Plains, NY 10601</u>	<input type="checkbox"/> Authorized	_____
Person		Person	
<input checked="" type="checkbox"/> Secretary	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Manager	Name: _____	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person		Person	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Important Notice: Use an attachment to report more than six (6). The attachment will be imaged for reporting purposes only. Non-indexed individuals may be added to the index when filling your Florida Department of State Annual Report form.

9. Attached is a certificate of existence, no more than 90 days old, duly authenticated by the official having custody of records in the jurisdiction under the law of which it is organized. (If the certificate is in a foreign language, a translation of the certificate under oath of the translator must be submitted)

10. 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.

  
Signature of an authorized person

Douglas Malton, Secretary and Authorized Person

# Delaware

Page 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF  
DELAWARE, DO HEREBY CERTIFY "TRINITY MEDICAL PHYSICIAN SERVICES,  
LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS  
IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF  
THIS OFFICE SHOW, AS OF THE FIFTEENTH DAY OF MAY, A.D. 2020.

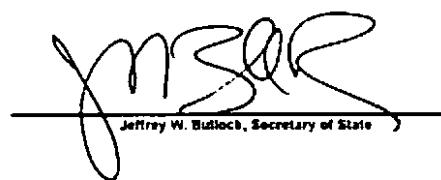
AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN  
ASSESSED TO DATE.



7945690 8300

SR# 20203997554

You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)



Jeffrey W. Bullock, Secretary of State

Authentication: 202940484

Date: 05-15-20