H20000044895

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

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JUN 01 2020

CORPORATION SERVICE COMPANY
1201 Hays Street
Tallhassee, FL 32301
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 285968 4304417

AUTHORIZATION :

COST LIMIT : $ 160.00

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ORDER DATE : May 11, 2020

ORDER TIME : 12:22 PM

ORDER NO. : 285968-040

CUSTOMER NO: 4304417

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FOREIGN FILINGS

NAME: SEASONS HEALTHCARE STAFFING, LLC

XXXX QUALIFICATION (TYPE: LL)

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

XX CERTIFIED COPY
_____ PLAIN STAMPED COPY
XX CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Amanda Robinson -- EXT# 62968

EXAMINER: _____

**COVER LETTER**

**TO:** **Registration Section**
**Division of Corporations**

**SUBJECT:** Seasons Healthcare Staffing, LLC
Name of Limited Liability Company

The enclosed "Application by Foreign Limited Liability Company for Authorization to Transact Business in Florida," Certificate of Existence, and check are submitted to register the above referenced foreign limited liability company to transact business in Florida.

Please return all correspondence concerning this matter to the following:

Jami McKenna, Corp. Paralegal
Name of Person

Much Shelist, P.C.
Firm/Company

191 N. Wacker Drive, Ste. 1800
Address

Chicago, IL 60606
City/State and Zip Code

jmckenna@muchlaw.com
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Jami McKenna at (312) 521-2447
Name of Contact Person — Area Code — Daytime Telephone Number

**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

Enclosed is a check for the following amount:
Please make check payable to: **FLORIDA DEPARTMENT OF STATE**

☐ $125.00 Filing Fee ☐ $130.00 Filing Fee & Certificate of Status ☐ $155.00 Filing Fee & Certified Copy ■ $160.00 Filing Fee, Certificate of Status & Certified Copy

**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. Seasons Healthcare Staffing, 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
(Jurisdiction under the law of which foreign limited liability company is organized)

3. 85-0978590
(FEI number, if applicable)

4. 06/01/2020
(Date first transacted business in Florida, if prior to registration.)
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)

5. 6400 Shafer Court, #700
Rosemont, IL 60018
(Street Address of Principal Office)

6.
(Mailing Address)

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

Name: Corporation Service Company

Office Address: 1201 Hays Street

Tallahassee (City), Florida 32301 (Zip code)

FILED
2021 JUL 27 PM 12:31
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

**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.***

Amanda E. Robinson Amanda Robinson, Asst. Vice President
(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]:

| Title or Capacity: | Name and Address: | Title or Capacity: | Name and Address: |
|---|---|---|---|
| ☐Manager | Name: Todd Stern | ☐Manager | Name: |
| ■Member | Address: 6400 Shafer Ct., Suite 700 Rosemont, IL 60018 | ☐Member | Address: |
| ☐Authorized | | ☐Authorized | |
| Person | | Person | |
| ☐Other | ☐Other | ☐Other | ☐Other |
| ☐Manager | Name: | ☐Manager | Name: |
| ☐Member | Address: | ☐Member | Address: |
| ☐Authorized | | ☐Authorized | |
| Person | | Person | |
| ☐Other | ☐Other | ☐Other | ☐Other |
| ☐Manager | Name: | ☐Manager | Name: |
| ☐Member | Address: | ☐Member | Address: |
| ☐Authorized | | ☐Authorized | |
| Person | | Person | |
| ☐Other | ☐Other | ☐Other | ☐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 filing 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

Todd Stern

Typed or printed name of signee

# Delaware

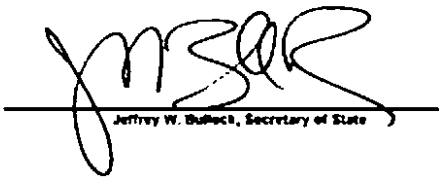
The First State



*I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SEASONS HEALTHCARE STAFFING, 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 ELEVENTH DAY OF MAY, A.D. 2020.*

*AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "SEASONS HEALTHCARE STAFFING, LLC" WAS FORMED ON THE SIXTH DAY OF MAY, A.D. 2020.*

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





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SR# 20203715432

Authentication: 202909954

Date: 05-11-20

You may verify this certificate online at corp.delaware.gov/authver.shtml