

11/13/2020

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Florida Department of State
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To:

Division of Corporations
Fax Number : (850)617-6383

From:

Account Name : C T CORPORATION SYSTEM
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Phone : (614)280-3338
Fax Number : (954)288-0845

****Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.****

Email Address: _____

Foreign Limited Liability Company
FLORIDA CARE PARTNERS TALLAHASSEE, LLC

Certificate of Status	0
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SBF
11/16/20

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. Florida Care Partners Tallahassee, 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)

84-5011330

3.

(FEI number, if applicable)

4. Upon filing

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

5. One Park Plaza

(Street Address of Principal Office)

P.O. Box 750

6.

(Mailing Address)

Nashville, TN 37203

Nashville, TN 37202

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

Name: C T Corporation System

Office Address: 1200 South Pine Island Road

Plantation, Florida 33324
(City) (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.

By: Nathan Giffin Nathan Giffin - 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>Florida Care Partners, LLC</u>	<input checked="" type="checkbox"/> Manager	Name: <u>Brian Allen</u>
<input checked="" type="checkbox"/> Member	Address: <u>One Park Plaza</u>	<input type="checkbox"/> Member	Address: <u>6400 Sanger Road</u>
<input type="checkbox"/> Authorized	<u>Nashville, TN 37203</u>	<input type="checkbox"/> Authorized	<u>Orlando, FL 32827</u>
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input checked="" type="checkbox"/> Manager	Name: <u>Allen Dunn</u>	<input checked="" type="checkbox"/> Manager	Name: <u>Kristin Dyer</u>
<input type="checkbox"/> Member	Address: <u>6400 Sanger Road</u>	<input type="checkbox"/> Member	Address: <u>101 N. Monroe St., Ste. 801</u>
<input type="checkbox"/> Authorized	<u>Orlando, FL 32827</u>	<input type="checkbox"/> Authorized	<u>Tallahassee, FL 32301</u>
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<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 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.

W. Tedrick Johnson

W. Tedrick Johnson (Nov 10 2020 16:34 CST)

Signature of an authorized person

W. Tedrick Johnson

Typed or printed name of signer

Delaware

The First State

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I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "FLORIDA CARE PARTNERS TALLAHASSEE, 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 THIRTEENTH DAY OF NOVEMBER, A.D. 2020.

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



7875685 8300

SR# 20208386550

You may verify this certificate online at corp.delaware.gov/authver.shtmlA handwritten signature in black ink, appearing to read "JB", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed in a small font.

Jeffrey W. Bullock, Secretary of State

Authentication: 204073012

Date: 11-13-20