

1/14/2021

Division of Corporations

Florida Department of State
Division of Corporations
Electronic Filing Cover Sheet

M2100000596

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To:

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

From:

Account Name : C T CORPORATION SYSTEM
Account Number : FCA000000023
Phone : (614)280-3338
Fax Number : (954)208-0845

****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

Doctor 'S Medical Center, LLC

Certificate of Status	0
Certified Copy	1
Page Count	04
Estimated Charge	\$155.00

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Corporate Filing Menu

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TALLAHASSEE, FLORIDA

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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. Doctor's Medical Center, LLC
(Name of Foreign Limited Liability Company; 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. N/A
(FEI number, if applicable)
4. Upon qualification
(Date first transacted business in Florida, if prior to registration.)
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)
5. 5605 NW 82nd Avenue
(Street Address of Principal Office)
6. 5605 NW 82nd Avenue
(Mailing Address)
- Doral, FL 33166
- Doral, FL 33166

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

Name: Ventura De Paz

Office Address: 5605 NW 82nd Avenue

Doral, 33166
(City) , 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.

[Signature]
(Registered agent's signature)

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STATE OF FLORIDA
TALLAHASSEE

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers of 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: Ventura De Paz	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 5605 NW 82nd Avenue	<input type="checkbox"/> Member	Address: _____
<input checked="" type="checkbox"/> Authorized	Doral, FL 33166	<input type="checkbox"/> Authorized	_____
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 _____
 <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.

Signature of an authorized person

Ventura De Paz

Typed or printed name of signer

Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DOCTOR'S MEDICAL CENTER, 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 FOURTEENTH DAY OF JANUARY, A.D. 2021.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "DOCTOR'S MEDICAL CENTER, LLC" WAS FORMED ON THE TWENTY-EIGHTH DAY OF DECEMBER, A.D. 2020.

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

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2021 JAN 14 PM 5:26
CLERK OF THE STATE
TALLAHASSEE, FLORIDA



4547693 8300

SR# 20210113912

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

A 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.

Authentication: 202288965

Date: 01-14-21