

5/13/2021

Division of Corporations

Florida Department of State
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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.****

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SECRETARY OF STATE

**Foreign Limited Liability Company
CAREMOUNT HEALTH SOLUTIONS, LLC**

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

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5/13/21

DocuSign Envelope ID: FDA7EA62-D84F-486A-835E-4B1E7E41C5D8

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. CAREMOUNT HEALTH SOLUTIONS, 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.

(FEI number, if applicable)

4.

(Date first transacted business in Florida, if prior to registration)
(See sections 605.0901 & 605.0905, F.S. to determine penalty liability)

90 SOUTH BEDFORD ROAD

5. (Street Address of Principal Office)

MOUNT KISCO, NEW YORK, 10549

90 SOUTH BEDFORD ROAD

6. (Mailing Address)

MOUNT KISCO, NEW YORK, 10549

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

(City)

, Florida

33324

(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: Michele Miller C T Corporation System Michele Miller, Asst. Secretary
(Registered agent's signature)

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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>Scott D. Hayworth, M.D.</u>	<input type="checkbox"/> Manager	Name: _____
<input checked="" type="checkbox"/> Member	Address: <u>90 SOUTH BEDFORD ROAD</u>	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	<u>MOUNT KISCO, NEW YORK, 10549</u>	<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: <u>Wyatt W. Decker, M.D.</u>	<input type="checkbox"/> Manager	Name: _____
<input checked="" type="checkbox"/> Member	Address: <u>90 SOUTH BEDFORD ROAD</u>	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	<u>MOUNT KISCO, NEW YORK, 10549</u>	<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.

DocuSigned by:

sdhayworth@prohealthcare.com

768BB3619C7E4DD..

Signature of an authorized person

Scott D. Hayworth, Member

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 "CAREMOUNT HEALTH SOLUTIONS, 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 TWELFTH DAY OF MAY, A.D. 2021.

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



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.

6842513 8300

SR# 20211734977

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

Authentication: 203185800

Date: 05-12-21