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Florida Department of State
Division of Corporations
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To: Division of Corporations
Fax Number : (850) 617-6383

From: Account Name : CAPITOL SERVICES, INC.
Account Number : 120160000017
Phone : (855) 498-5500
Fax Number : (800) 432-3622

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
MIAMI MEDICAL CLINIC, LLC

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

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IT WAS A TYPO ON MY END WHEN
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\$793.75

***PLEASE PROVIDE THE
ORIGINAL SUBMISSION
DATE OF 7/21/21

**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. Miami Medical Clinic, I.L.C.
(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. _____
(FBI number, if applicable)

4. 12/22/2020
(Date first transacted business in Florida, if prior to registration.)
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)

5. 1180 Drummond St., Ste 400
(Street Address of Principal Office)

6. _____
(Mailing Address)

Montréal, QC H3G 2S1

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

Name: Capitol Corporate Services, Inc.

Office Address: 515 East Park Avenue, 2nd Floor

Tallahassee, Florida 32301
(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.

Taylor Seay

Taylor Seay, Asst. Sec. on behalf
of Capitol Corporate Services, Inc.

(Registered agent's signature)

FILED
2021 JUL 21 PM 4:08
CLERK OF DISTRICT COURT
TALLAHASSEE, FLORIDA

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 checked="" type="checkbox"/> Manager	Name: <u>Alan Marshall</u>	<input type="checkbox"/> Manager	Name: <u>LMD LMC Holdings, LLC</u>
<input type="checkbox"/> Member	Address: <u>1180 Drummond St., Ste 400</u>	<input checked="" type="checkbox"/> Member	Address: <u>1180 Drummond St., Ste 400</u>
<input type="checkbox"/> Authorized	<u>Montréal, QC H3G 2S1</u>	<input type="checkbox"/> Authorized	<u>Montréal, QC H3G 2S1</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 _____
<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.

A. Marshall
Signature of an authorized person

Alan Marshall

Typed or printed name of signee

Delaware

The First State

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I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "MIAMI MEDICAL CLINIC, 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 TWENTY-FIRST DAY OF JULY, A.D. 2021.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "MIAMI MEDICAL CLINIC, LLC" WAS FORMED ON THE SEVENTH DAY OF OCTOBER, A.D. 2020.

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

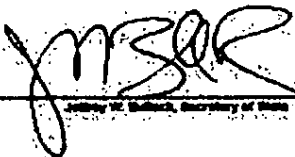
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2021 JUL 21 PM 4:08
J. W. BULLOCK, SECRETARY OF STATE
DELAWARE



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


Jeffrey W. Bullock, Secretary of State

Authentication: 203729120

Date: 07-21-21