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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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TALLAHASSEE, FLORIDA  
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## FOREIGN PROFIT/NONPROFIT CORPORATION Atria Physician Practice, P.C.

|                       |         |
|-----------------------|---------|
| Certificate of Status | 0       |
| Certified Copy        | 1       |
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TALLAHASSEE, FLORIDA

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**APPLICATION BY FOREIGN CORPORATION FOR AUTHORIZATION TO TRANSACT BUSINESS IN FLORIDA**

*IN COMPLIANCE WITH SECTION 607.1503, FLORIDA STATUTES, THE FOLLOWING IS SUBMITTED TO REGISTER A FOREIGN CORPORATION TO TRANSACT BUSINESS IN THE STATE OF FLORIDA.*

1. Atria Physician Practice, P.C.  
 (Enter name of corporation; must include "INCORPORATED," "COMPANY," "CORPORATION," "Inc.," "Co.," "Corp.," "Inc.," "Co.," or "Corp.")

Atria Physician Practice, P.C. Corp.  
 (If name unavailable in Florida, enter alternate corporate name adopted for the purpose of transacting business in Florida)

2. Pennsylvania 3. Applied for  
 (State or country under the law of which it is incorporated) (FEI number, if applicable)

4. 03/17/2021 5. \_\_\_\_\_  
 (Date of incorporation) (Date of duration, if other than perpetual)

6. \_\_\_\_\_  
 upon qualification  
 (Date first transacted business in Florida, if prior to registration)  
 (SEE SECTIONS 607.1501 & 607.1502, F.S., to determine penalty liability)

7. 36 E. 57th St., 5th Floor, New York, NY 10022  
 (Principal office street address)

\_\_\_\_\_  
(Current mailing address, if different)

8. 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)

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9. **Registered agent's acceptance:**  
*Having been named as registered agent and to accept service of process for the above stated corporation 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.*

/s/ David Westcott, Assistant Secretary  
 \_\_\_\_\_  
 (Registered agent's signature)

10. Attached is a certificate of existence duly authenticated, not more than 90 days prior to delivery of this application to the Department of State, by the Secretary of State or other official having custody of corporate records in the jurisdiction under the law of which it is incorporated.

11. For initial indexing purposes, list names, titles and addresses of the primary officers and/or directors [up to six (6) total]:

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A. DIRECTORS

Chairman Name: Kenneth Hillel Shubin Stein, M.D.  
 36 E. 57th St., 5th Fl,  
 Vice Chairman Address: New York, NY 10022  
 Director \_\_\_\_\_  
 President \_\_\_\_\_  
 Vice President \_\_\_\_\_  
 Secretary  Treasurer  
 Other \_\_\_\_\_  Other \_\_\_\_\_

Chairman Name: \_\_\_\_\_  
 Vice Chairman Address: \_\_\_\_\_  
 Director \_\_\_\_\_  
 President \_\_\_\_\_  
 Vice President \_\_\_\_\_  
 Secretary  Treasurer  
 Other \_\_\_\_\_  Other \_\_\_\_\_

Chairman Name: \_\_\_\_\_  
 Vice Chairman Address: \_\_\_\_\_  
 Director \_\_\_\_\_  
 President \_\_\_\_\_  
 Vice President \_\_\_\_\_  
 Secretary  Treasurer  
 Other \_\_\_\_\_  Other \_\_\_\_\_

Chairman Name: \_\_\_\_\_  
 Vice Chairman Address: \_\_\_\_\_  
 Director \_\_\_\_\_  
 President \_\_\_\_\_  
 Vice President \_\_\_\_\_  
 Secretary  Treasurer  
 Other \_\_\_\_\_  Other \_\_\_\_\_

Chairman Name: \_\_\_\_\_  
 Vice Chairman Address: \_\_\_\_\_  
 Director \_\_\_\_\_  
 President \_\_\_\_\_  
 Vice President \_\_\_\_\_  
 Secretary  Treasurer  
 Other \_\_\_\_\_  Other \_\_\_\_\_

Chairman Name: \_\_\_\_\_  
 Vice Chairman Address: \_\_\_\_\_  
 Director \_\_\_\_\_  
 President \_\_\_\_\_  
 Vice President \_\_\_\_\_  
 Secretary  Treasurer  
 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.

12. K.S.  
Signature of Director or Officer

The officer or director signing this document (and who is listed in number 11 above) affirms that the facts stated herein are true and that he or she is aware that 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.

13. Kenneth Hillel Shubin Stein, M.D., President/Secretary/Treasurer  
(Typed or printed name and capacity of person signing application)

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
11/30/2021

TO ALL WHOM THESE PRESENTS SHALL COME, GREETING:

I DO HEREBY CERTIFY THAT,

Atria Physician Practice, P.C.

is duly registered as a Pennsylvania Professional Corporation under the laws of the Commonwealth of Pennsylvania and remains subsisting so far as the records of this office show, as of the date herein.

I DO FURTHER CERTIFY THAT this Subsistence Certificate shall not imply that all fees, taxes and penalties owed to the Commonwealth of Pennsylvania are paid.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Seal of the Secretary's Office to be affixed, the day and year above written

A handwritten signature in cursive script that reads "Thomas W. DeGrego".

Acting Secretary of the Commonwealth

Certification Number: TSC211130162187-1

Verify this certificate online at <http://www.corporations.pa.gov/orders/verify>