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(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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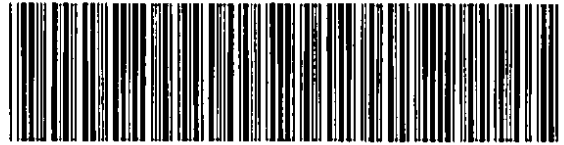
(Business Entity Name)

(Document Number)

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2022 MAY -6 AM 7:35
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

FILED

04/18/22--01032--007 **160.00

COVER LETTER

**TO: Registration Section
Division of Corporations**

SUBJECT: Innovative Physician Services, LLC

Name of Limited Liability Company

The enclosed "Application by Foreign Limited Liability Company for Authorization to Transact Business in Florida," Certificate of Existence, and check are submitted to register the above referenced foreign limited liability company to transact business in Florida.

Please return all correspondence concerning this matter to the following:

Carmela Bonavita

Name of Person

Innovative Physician Services, LLC

Firm/Company

95 Frank B. Murray St

Address

Springfield, MA 01103

City/State and Zip Code

carmela@teamrehabcenter.com

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Carmela Bonavita

413

575-5572

at (_____) _____

Name of Contact Person

Area Code

Daytime Telephone Number

Mailing Address:

Registration Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Street Address:

Registration Section
Division of Corporations
The Centre of Tallahassee
2415 N. Monroe Street, Suite 810
Tallahassee, FL 32303

Enclosed is a check for the following amount:

Please make check payable to: **FLORIDA DEPARTMENT OF STATE**

☐ \$125.00 Filing Fee

☐ \$130.00 Filing Fee &
Certificate of Status

☐ \$155.00 Filing Fee &
Certified Copy

☒ \$160.00 Filing Fee, Certificate
of Status & Certified Copy

**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. Innovative Physician Services, 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. Massachusetts 3. 65-1170561
(Jurisdiction under the law of which foreign limited liability company is organized) (FEI number, if applicable)

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

5. 95 Frank B Murray St
(Street Address of Principal Office)

6. 95 Frank B Murray St
(Mailing Address)

Springfield, MA 01103

Springfield, MA 01103

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

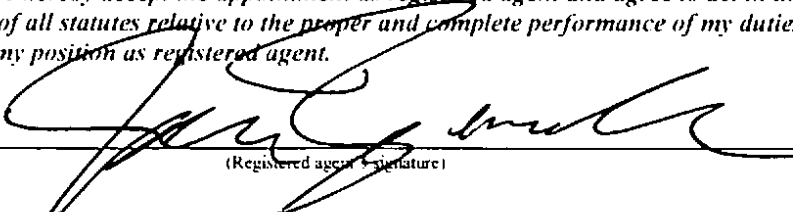
Name: Jose Fernandez

Office Address: 5058 Brightmour Circle

Orlando, Florida 32837
(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.


(Registered agent's signature)

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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: Jose Fernandez	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 5058 Brightmour Circle	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	Orlando, FL 32837	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input checked="" type="checkbox"/> Manager	Name: Carmela Bonavita	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 95 Frank B Murray st	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	Springfield, MA 01103	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input checked="" type="checkbox"/> Manager	Name: Juan Salgado	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 95 Frank B Murray St	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	Springfield, MA 01103	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

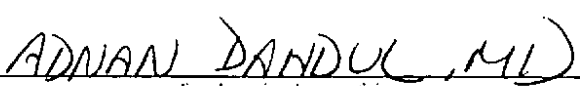
Important Notice: Use an attachment to report more than six (6). The attachment will be imaged for reporting purposes only. Non-indexed individuals may be added to the index when filing your Florida Department of State Annual Report form.

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



Typed or printed name of signee



William Francis Calvin
Secretary of the
Commonwealth

The Commonwealth of Massachusetts
Secretary of the Commonwealth
State House, Boston, Massachusetts 02133

Date: May 06, 2022

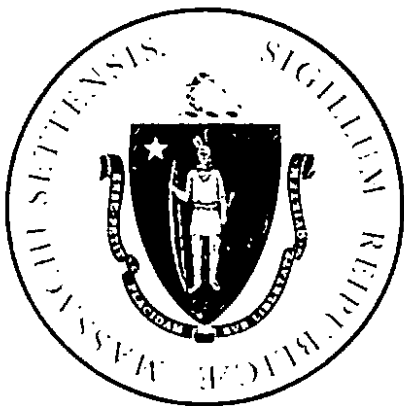
To Whom It May Concern :

I hereby certify that a certificate of organization of Limited Liability Company was filed
in this office by

INNOVATIVE PHYSICIAN SERVICES, LLC

in accordance with the provisions of Massachusetts General Laws, Chapter 156C, on
April 07, 2003.

I further certify that said Limited Liability Company has not filed a Certificate of Cancellation;
that said Limited Liability Company has not been administratively dissolved; and that, so far as
appears of record, said Limited Liability Company has legal existence.



In testimony of which,
I have hereunto affixed the
Great Seal of the Commonwealth
on the date first above written.

William Francis Calvin

Secretary of the Commonwealth

Certificate Number: 22050124440

Verify this Certificate at: <http://corp.sec.state.ma.us/CorpWeb/Certificates/Verify.aspx>

Processed by: Bod