

# M22000013629

(Requestor's Name)

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(Address)

(City/State/Zip/Phone #)

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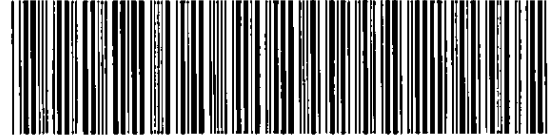
(Business Entity Name)

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S. ROBERTS

AUG 31 2022

# CT CORP

3458 Lakeshore Drive, Tallahassee, FL 32312  
850-656-4724

Date: 08/31/2022

Acc#I20160000072

*W: L D W*

Name:	Critical Care Medical Management Associates, PLLC
Document #:	
Order #:	14519361

Certified Copy of Arts & Amend:	<input type="checkbox"/>			
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Certificate of Good Standing:	<input type="checkbox"/>			
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Amount: \$ 155.00
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Thank you!

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT: CRITICAL CARE MEDICAL MANAGEMENT ASSOCIATES, PLLC**

\_\_\_\_\_  
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:

CHARLOTTE ROORK

\_\_\_\_\_  
Name of Person

MCDERMOTT WILL & EMERY LLP

\_\_\_\_\_  
Firm/Company

444 W LAKE ST STE 4000

\_\_\_\_\_  
Address

CHICAGO IL 60606

\_\_\_\_\_  
City/State and Zip Code

CROORK@MWE.COM

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

For further information concerning this matter, please call:

CHARLOTTE ROORK

312

899-7286

\_\_\_\_\_  
Name of Contact Person

at (\_\_\_\_\_) \_\_\_\_\_

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. CRITICAL CARE MEDICAL MANAGEMENT ASSOCIATES, PLLC

(Name of Foreign Limited Liability Company, must include "Limited Liability Company," "L.L.C.," or "LLC.")

CRITICAL CARE MEDICAL MANAGEMENT ASSOCIATES, 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. NEW YORK

(Jurisdiction under the law of which foreign limited liability company is organized)

3. N/A

(FLL 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.)

5. 2 PARK AVENUE SUITE 2039

(Street Address of Principal Office)

NEW YORK, NY 10016

6. 2 PARK AVENUE SUITE 2039

(Mailing Address)

NEW YORK, NY 10016

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.*

Bernadette Baker, Bernadette Baker, Asst. Sec.

(Registered agent's signature)

2022 AUG 31 AM 11:09

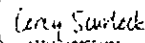
8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage [up to six (6) total]:

<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: COREY SCURLOCK	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 2 PARK AVENUE	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	SUITE 2039	<input type="checkbox"/> Authorized	_____
Person	NEW YORK, NY 10016	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.

DocuSigned by  
  
 Corey Scurlock

Signature of an authorized person

COREY SCURLOCK, MANAGER

Typed or printed name of signee

STATE OF NEW YORK

DEPARTMENT OF STATE

Certificate of Status

I, ROBERT J. RODRIGUEZ, Secretary of State of the State of New York and custodian of the records required by law to be filed in my office, do hereby certify that upon a diligent examination of the records of the Department of State, as of the date and time of this certificate, the following entity information is reflected:

Entity Name:	CRITICAL CARE MEDICAL MANAGEMENT ASSOCIATES, PLLC
DOS ID Number:	4143389
Entity Type:	DOMESTIC PROFESSIONAL SERVICE LIMITED LIABILITY COMP ANY
Entity Status:	EXISTING
Date of Initial Filing with DOS:	09/19/2011
Statement Status:	CURRENT
Statement Due Date:	09/30/2023

I certify that the following is a list of documents on file in the Department of State for said entity:

Document Type:	ARTICLES OF ORGANIZATION
Date of Filing:	09/19/2011
Entity Name:	CRITICAL CARE MEDICAL MANAGEMENT ASSOCIATES, PLLC

Document Type:	CERTIFICATE OF PUBLICATION
Date of Filing:	01/04/2012

Document Type:	BIENNIAL STATEMENT
Date of Filing:	08/19/2022
Effective Date:	09/01/2021

Above space is left blank intentionally.

No information is available from this office regarding the financial condition, business activity or practices of this entity.

WITNESS my hand and official seal of the Department  
of State, at the City of Albany, on August 19, 2022 at  
11:56 A.M.



ROBERT J. RODRIGUEZ, Secretary of State

*Brendan C. Hughes*

By Brendan C. Hughes  
Executive Deputy Secretary of State