

M23000002817

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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C. Brumby

CT CORP

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

Date: 03/06/2023

Acc#I20160000072

W: C DW

Name:	InnovaCare Physician Management Services, LLC
Document #:	
Order #:	14812773 - 6

Certified Copy of Arts & Amend:	<input type="checkbox"/>		
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Email Address for Annual Report Notifications:

david.dawn@innovacarehealth.com

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Amount: \$ 155.00

Thank you!

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. INNOVACARE PHYSICIAN MANAGEMENT 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. DE

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

3.

(FEI number, if applicable)

4. 11/17/2022

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

5.

(Street Address of Principal Office)

6900 Tavistock Lakes Boulevard Suite 300

Orlando, FL 32827

6.

(Mailing Address)

6900 Tavistock Lakes Boulevard Suite 300

Orlando, FL 32827

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)

33324

Florida

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

APPROVED
AND
FILED

2023 MAR -6 AM 11:18

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>Leslie Prizant</u>	<input type="checkbox"/> Manager	Name: _____
<input checked="" type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	<u>6900 Tavistock Lakes Blvd Suite 300</u>	<input type="checkbox"/> Authorized	_____
Person	<u>Orlando, FL 32827</u>	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:

Leslie Prizant

3A2494ECCABF4AA

Signature of an authorized person

Leslie Prizant, Member

Typed or printed name of signer

Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF
DELAWARE, DO HEREBY CERTIFY "INNOVACARE PHYSICIAN MANAGEMENT
SERVICES, 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 THIRD DAY OF MARCH,
A.D. 2023.

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



7143525 8300

SR# 20230858075

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

A handwritten signature in black ink, appearing to read "JBullock", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed in a small font.

Authentication: 202831315

Date: 03-03-23