M23000012833

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer:

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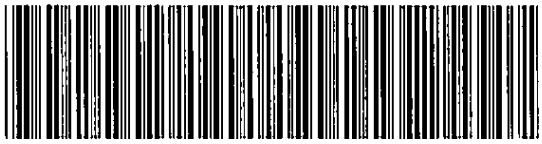

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DIVISION OF CORPORATIONS
TALLAHASSEE, FLORIDA

FLORIDA FILING & SEARCH SERVICES, INC.

P.O. BOX 10662 TALLAHASSEE, FL 32302
155 Office Plaza Dr Ste A Tallahassee FL 32301
PHONE: (800) 435-9371; FAX: (866) 860-8395

DATE: 11/30/2023

NAME: MEDICAL REHAB PRO LLC

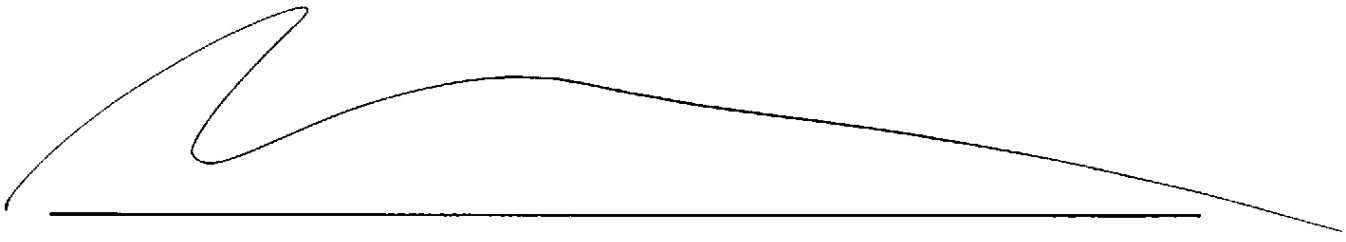
TYPE OF FILING: AMENDMENT APPLICATION

COST: 60.00

RETURN: CERTIFIED COPY AND GOOD STANDING PLEASE

ACCOUNT: **FCA000000015**

AUTHORIZATION: ABBIE/PAUL HODGE



COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: MEDICAL REHAB PRO LLC
Name of Foreign Limited Liability Company

Dear Sir or Madam:

The enclosed application, certificate and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Dr. DIANE A. THOMPSON, MD
Name of Person

MEDICAL REHAB PRO LLC
Firm/Company

700 S Rosemary Avenue, Suite 204
Address

WEST PALM BEACH, FL 33401
City/State and Zip Code

medicalrehabpro@gmail.com
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

DIANE A. THOMPSON, MD at (917) 250.3380
Name of 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:

☐ $25 Filing Fee ☐ $30 Filing Fee & Certificate of Status ☐ $55 Filing Fee & Certified Copy ☒ $60 Filing Fee, Certificate of Status & Certified Copy

CR2E055 (9/15)

APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY TO FILE AMENDMENT TO CERTIFICATE OF AUTHORITY TO TRANSACT BUSINESS IN FLORIDA

SECTION I (1-4 must be completed)

1. Name of limited liability Company as it appears on the records of the Florida Department of

State: MEDICAL REHAB PRO LLC

Enter new principal office address, if applicable: _____

(Principal office address MUST BE A STREET ADDRESS) _____

_____

Enter new mailing address, if applicable: _____

(Mailing address MAY BE A POST OFFICE BOX) _____

_____

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

2. The Florida document number of this limited liability company is: M23000012833

3. Jurisdiction of its organization: DELAWARE

4. Date authorized to do business in Florida: 10/5/2023

SECTION II (5-9 complete only the applicable changes)

5. New name of the limited liability company: _____
(must contain "Limited Liability Company," "L.L.C.," or "LLC.")

_____
(If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida and attach a copy of the written consent of the managers or managing members adopting the alternate name. The alternate name must contain "Limited Liability Company," "L.L.C." or "LLC.")

6. If amending the registered agent and/or registered officer address on our records, enter the name of the new registered agent and/or the new registered office address here:

Name of New Registered Agent: _____

New Registered Office Address: _____
Enter Florida Street Address

_____, **Florida** _____
City *Zip Code*

New Registered Agent's Signature, if changing Registered Agent:
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 as provided for in Chapter 605, F.S. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.

_____
If Changing Registered Agent, Signature of New Registered Agent

7. If the amendment changes the jurisdiction of organization, indicate new jurisdiction:

_____

8. If the amendment changes person, title or capacity in accordance with 605.0902 (1)(e), indicate that change:

Name Change of Person and Title

Title/ Capacity	Name	Address	Type of Action
MGR	D.T. Drummon	700 S. Rosemary West Palm Beach FL	☐Add
			■Remove
MGR	DR.DIANE A. THOMSPON, MD	700 S. Rosemary West Palm Beach FL	■Add
			☐Remove
			☐Add
			☐Remove
			☐Add
			☐Remove
			☐Add
			☐Remove

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TALLAHASSEE, FLORIDA

9. Attached is a certificate, if required: no more than 90 days old, evidencing the aforementioned amendment(s), duly authenticated by the official having custody of records in the jurisdiction under the law of which this entity is organized.

_____
Signature of the authorized representative

Dr. Diane A. Thompson, MD

_____
Typed or printed name of signee

Filing Fee: $25.00