



To:

Page 2 of 7

2023-12-28 18:25 04 GMT

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From Alexander England

850-617-6381

12/28/2023 12:38:59 PM PAGE 1/001 Fax Server



December 28, 2023

FLORIDA DEPARTMENT OF STATE  
Division of Corporations

INTERSTATE FILINGS LLC

SUBJECT: FULL CIRCLE PSYCHOTHERAPY LCSW, PLLC  
REF: W23000170091

We received your electronically transmitted document. However, the document has not been filed. Please make the following corrections and refax the complete document, including the electronic filing cover sheet.

Florida law does not provide for the recognition of a foreign professional limited liability company. An acceptable limited liability company suffix will need to be added to your entity name for this Department to accept and file your document.

If you have any questions concerning the filing of your document, please call (850) 245-6051.

Mel Solomon  
Operations Manager A

FAX Aud. #: H23000439904  
Letter Number: 523A00029417

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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. FULL CIRCLE PSYCHOTHERAPY LCSW, PLLC, 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. NEW YORK  
(Jurisdiction under the law of which foreign limited liability company is organized)

3. (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. 3319 SOUTH FEDERAL HIGHWAY, APT E  
(Street Address of Principal Office)

6. 3319 SOUTH FEDERAL HIGHWAY, APT E  
(Mailing Address)

BOYNTON BEACH, FL 33435

BOYNTON BEACH, FL 33435

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

Name MARISSA JACCOBI

Office Address: 3319 SOUTH FEDERAL HIGHWAY, APT E

BOYNTON BEACH 33435  
(City) Florida (Zip code)

2023 DEC 28 PM 4:44

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.

Marissa Jacobi  
(Registered agent's signature)

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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>MARISSA JACCOBI</u>	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: <u>3319 S. FEDERAL HWY</u>	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	<u>APARTMENT E</u>	<input type="checkbox"/> Authorized	_____
Person	<u>BOYNTON BEACH, FL 33435</u>	Person	_____
<input checked="" type="checkbox"/> Other <u>MGMB</u>	<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 817.133, F.S.

*Marissa Jacobi*

Signature of an authorized person

MARISSA JACCOBI

Typed or printed name of signer

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## 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: FULL CIRCLE PSYCHOTHERAPY LCSW, PLLC  
DOS ID Number: 6336163  
Entity Type: DOMESTIC PROFESSIONAL SERVICE LIMITED LIABILITY COMP ANY  
Entity Status: EXISTING  
Date of Initial Filing with DOS: 11/24/2021  
Statement Status: CURRENT  
Statement Due Date: 11/30/2025

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: 11/24/2021  
Entity Name: FULL CIRCLE PSYCHOTHERAPY LCSW, PLLC

Document Type: CERTIFICATE OF CHANGE BY ENTITY  
Date of Filing: 01/21/2022

Document Type: CERTIFICATE OF PUBLICATION  
Date of Filing: 03/23/2022

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**Document Type:** BIENNIAL STATEMENT  
**Date of Filing:** 12/27/2023

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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 December 27, 2023  
at 03:49 P.M.



ROBERT J. RODRIGUEZ, Secretary of State

*Brendan C. Hughes*

By Brendan C. Hughes  
Executive Deputy Secretary of State

Authentication Number: 100004901788 To Verify the authenticity of this document you may access the  
Division of Corporation's Document Authentication Website at <http://ecorp.dos.ny.gov>

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