

5/29/24, 10:56 AM

Division of Corporations

Florida Department of State
Division of Corporations
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From:

Account Name : SHUFFIELD LOWMAN
Account Number : I20030000118
Phone : (407)581-9800
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Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.**

Email Address: registeredagent-jad@shuffieldlowman.com

**Foreign Limited Liability Company
Muni Health, LLC**

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APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY FOR AUTHORIZATION TO TRANSACT BUSINESS
IN FLORIDAIN 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. MUNI HEALTH, LLC

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

(If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida. The alternate name must include "Limited Liability Company," "LLC," or "L.L.C.")

2. DELAWARE

99-2549245

(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)

1621 N. PENINSULA AVE.

1621 N. PENINSULA AVE.

5. (Street Address of Principal Office)

6. (Mailing Address)

NEW SMYRNA BEACH, FL 32169

NEW SMYRNA BEACH, FL 32169

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

Name: JASON A. DAVIS, ESQ.

Office Address: 1000 LEGION PLACE, SUITE 1700

ORLANDO

32801

(City)

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.

(Registered agent's signature)

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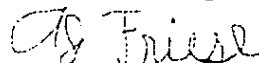
8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage (up to six (6) total):

<u>Title or Capacity:</u>	<u>Name and Address:</u>	<u>Title or Capacity:</u>	<u>Name and Address:</u>
<input checked="" type="checkbox"/> Manager	Name: ANTHONY J. FRIESL, IV	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: 1621 N. PENINSULA AVE.	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	NEW SMYRNA BEACH, FLORIDA 32169	<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 _____
<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.



Signature of an authorized person

ANTHONY J. FRIESL, IV

Typed or printed name of signer

Delaware

The First State

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I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "MUNI HEALTH, 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 TWENTY-EIGHTH DAY OF MAY, A.D. 2024.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "MUNI HEALTH, LLC" WAS FORMED ON THE SIXTEENTH DAY OF APRIL, A.D. 2024.

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



3456401 8300

SR# 20242522834

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: 203568537

Date: 05-28-24