

M24000015724

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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(Business Entity Name)

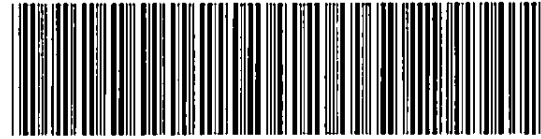
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2024 DEC 16 AM 11:36

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

APPROVED  
AND  
FILED

2024 DEC 16 AM 11:38

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DEC 17 2024

K. Brumbley

**COVER LETTER**

**TO: Registration Section  
Division of Corporations**

**SUBJECT:** Concierge Medical Management, LLC  
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:

Peter J. Mackey  
Name of Person

Mackey Law Group, P.A.  
Firm/Company

1402 3rd Ave W  
Address

Bradenton, FL 34205  
City/State and Zip Code

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

For further information concerning this matter, please call:

Peter J. Mackey at ( 941 ) 746-6225  
Name of Contact 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:

Please make check payable to: **FLORIDA DEPARTMENT OF STATE**

☐ \$125.00 Filing Fee    ☒ \$130.00 Filing Fee &    ☐ \$155.00 Filing Fee &    ☐ \$160.00 Filing Fee, Certificate  
Certificate of Status    Certified Copy    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. Concierge Medical Management, 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. Wyoming 3. \_\_\_\_\_  
(Jurisdiction under the law of which foreign limited liability company is organized) (FEI number, if applicable)

4. N/A  
(Date first transacted business in Florida, if prior to registration)  
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)

5. 1712 Pioneer Ave, Ste 500 6. 1712 Pioneer Ave, Ste 500  
(Street Address of Principal Office) (Mailing Address)

Cheyenne, WY 82001

Cheyenne, WY 82001

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

Name: Mackey Law Group, P.A.

Office Address: 1402 3rd Ave W

Bradenton, FL, Florida 34205  
(City) (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)

APPROVED  
AND  
FILED  
2024 DEC 16 AM 11:38  
CLERK OF THE CIRCUIT COURT  
IN AND FOR THE COUNTY OF HILLSBORO, FLORIDA

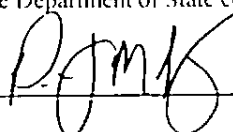
8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage [up to six (6) total]:

| <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>Dr. James W. Reed, III, MD</u> | <input type="checkbox"/> Manager               | Name: <u>Angie Weaver</u>            |
| <input checked="" type="checkbox"/> Member     | Address: <u>11410 Spring Gate Trl</u>   | <input checked="" type="checkbox"/> Member     | Address: <u>544 Bay Isles Rd</u>     |
| <input checked="" type="checkbox"/> Authorized | <u>Bradenton, FL 34211</u>              | <input checked="" type="checkbox"/> Authorized | <u>Longboat Key, FL 34228</u>        |
| 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

**Peter J. Mackey**

\_\_\_\_\_  
Typed or printed name of signer

**STATE OF WYOMING**  
**Office of the Secretary of State**

I, CHUCK GRAY, Secretary of State of the State of Wyoming, do hereby certify that according to the records of this office,

**Concierge Medical Management, LLC**  
is a  
**Limited Liability Company**

formed or qualified under the laws of Wyoming did on **May 13, 2020**, comply with all applicable requirements of this office. Its period of duration is Perpetual. This entity has been assigned entity identification number **2020-000916545**.

This entity is in existence and in good standing in this office and has filed all annual reports and paid all annual license taxes to date, or is not yet required to file such annual reports; and has not filed Articles of Dissolution.

I have affixed hereto the Great Seal of the State of Wyoming and duly generated, executed, authenticated, issued, delivered and communicated this official certificate at Cheyenne, Wyoming on this 25th day of October, 2024 at 9:35 AM. This certificate is assigned ID Number 077556526.



  
Secretary of State