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(Ci	ty/State/Zip/Phone	e #)		
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## TRANSMITTAL LETTER

Department of State
Division of Corporations
P. O. Box 6327
Tallahassee, FL 32314

SUBJECT: MAX	(PROPOSED CORPORA	DA, INC. TE NAME - <u>MUST INCL</u>	UDE SUFFIX)	
Enclosed is an origina	al and one(1) copy of the articl	es of incorporation and a	a check for :	
☎ \$70.00 Filing Fee	\$78.75 Filing Fee & Certificate of Status	\$78.75 Filing Fee & Certified Copy  ADDITIONAL CO	\$87.50 Filing Fee, Certified Copy & Certificate of Status PY REQUIRED	
FROM:	BRIAN SIMMONS			
Name (Printed or typed)  9266 NEWMAN CIRCLE				
	PORT CHARLOTTE, FL 33981  City, State & Zip			
941-916-1414  Daytime Telephone number				

NOTE: Please provide the original and one copy of the articles.

## ARTICLES OF INCORPORATION

In compliance with Chapter 607 and/or Chapter 621, F.S. (Profit)

#### <u>ARTICLE I</u> NAME

The name of the corporation shall be:

MAXIM ANESTHESIA OF FLORIDA, INC.

#### ARTICLE II PRINCIPAL OFFICE

The principal place of business/mailing address is:

9266 NEWMAN CIRCLE

PORT CHARLOTTE, FL 33981

### ARTICLE III **PURPOSE**

The purpose for which the corporation is organized is:

NURSE ANESTHESIA STAFFING

#### ARTICLE IV SHARES

The number of shares of stock is:

60,000

## ARTICLE V INITIAL OFFICERS DIRECT

The name(s) and address(es):

#### ARTICLE VI REGISTERED AGENT

The name and Florida street address of the registered agent is:

BRIAN SIMMONS

9266 NEWMAN CIRCLE

PORT CHARLOTTE, FL 33981

#### ARTICLE VII INCORPORATOR

The name and address of the Incorporator is:

BRIAN SIMMONS

9266 NEWMAN CIRCLE

PORT CHARLOTTE, FL 33981

Having been named as registered agent to accept service of process for the above stated corporation at the place designated in this certificate, I am familiar with and accept the appointment as registered agent and agree to act in this capacity

Signature/Registered Agent

Signature/Incorporator

x 8/27/04 Date x 8/27/04