P04000141663

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

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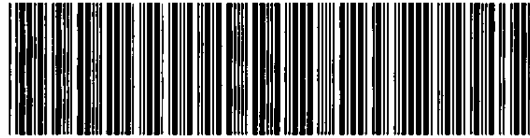

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06/28/10--01008--011 **35.00

FILED
2010 JUN 28 A 10: 36
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Amend NC
Thewis
6-29-10

COVER LETTER

TO: Amendment Section
Division of Corporations

NAME OF CORPORATION: O.M. HEALTH SERVICES P.A.

DOCUMENT NUMBER: P04000141663

The enclosed ***Articles of Amendment*** and fee are submitted for filing.

Please return all correspondence concerning this matter to the following:

OLY M. MENDEZ
Name of Contact Person

O.M. HEALTH SERVICES P.A.
Firm/ Company

17064 NW 17TH ST
Address

PEMBROKE PINES, FL 33028
City/ State and Zip Code

OLYMENDEZ@MSN.COM
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

OLY M. MENDEZ at (954) 818-4491
Name of Contact Person — Area Code & Daytime Telephone Number

Enclosed is a check for the following amount made payable to the Florida Department of State:

- ☑ $35 Filing Fee
- ☐ $43.75 Filing Fee & Certificate of Status
- ☐ $43.75 Filing Fee & Certified Copy (Additional copy is enclosed)
- ☐ $52.50 Filing Fee Certificate of Status Certified Copy (Additional Copy is enclosed)

Mailing Address
Amendment Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Street Address
Amendment Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, FL 32301

Articles of Amendment
to
Articles of Incorporation
of

FILED
2010 JUN 28 A 10:36
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

O.M. IMPEX CORPORATION
(Name of Corporation as currently filed with the Florida Dept. of State)

P04000141663
(Document Number of Corporation (if known)

Pursuant to the provisions of section 607.1006, Florida Statutes, this ***Florida Profit Corporation*** adopts the following amendment(s) to its Articles of Incorporation:

A. If amending name, enter the new name of the corporation:

O.M. HEALTH SERVICES P.A. *The new name must be distinguishable and contain the word "corporation," "company," or "incorporated" or the abbreviation "Corp.," "Inc.," or Co.," or the designation "Corp," "Inc," or "Co". A professional corporation name must contain the word "chartered," "professional association," or the abbreviation "P.A."*

B. Enter new principal office address, if applicable:
(Principal office address MUST BE A STREET ADDRESS)

____
____
____

C. Enter new mailing address, if applicable:
(Mailing address MAY BE A POST OFFICE BOX)

____
____
____

D. If amending the registered agent and/or registered office address in Florida, enter the name of the new registered agent and/or the new registered office address:

Name of New Registered Agent: ______________________

New Registered Office Address: ______________________
(Florida street address)

______________________, Florida__________
(City) *(Zip Code)*

New Registered Agent's Signature, if changing Registered Agent:
I hereby accept the appointment as registered agent. I am familiar with and accept the obligations of the position.

____
Signature of New Registered Agent, if changing

- **If amending the Officers and/or Directors, enter the title and name of each officer/director being removed and title, name, and address of each Officer and/or Director being added:**
  (Attach additional sheets, if necessary)

Title	Name	Address	Type of Action
			☐ Add ☐ Remove
			☐ Add ☐ Remove
			☐ Add ☐ Remove

E. **If amending or adding additional Articles, enter change(s) here:**
(attach additional sheets, if necessary). (Be specific)

ARTICLE III: PROVIDE PROFESSIONAL HEALTH CARE SERVICES BY AN ADVANCED REGISTERED NURSE PRACTITIONER

F. **If an amendment provides for an exchange, reclassification, or cancellation of issued shares, provisions for implementing the amendment if not contained in the amendment itself:**
(if not applicable, indicate N/A)

The date of each amendment(s) adoption: JUNE 24, 2010
(date of adoption is required)

Effective date if applicable: JUNE 24, 2010
(no more than 90 days after amendment file date)

Adoption of Amendment(s) **(CHECK ONE)**

☑ The amendment(s) was/were adopted by the shareholders. The number of votes cast for the amendment(s) by the shareholders was/were sufficient for approval.

☐ The amendment(s) was/were approved by the shareholders through voting groups. *The following statement must be separately provided for each voting group entitled to vote separately on the amendment(s):*

"The number of votes cast for the amendment(s) was/were sufficient for approval

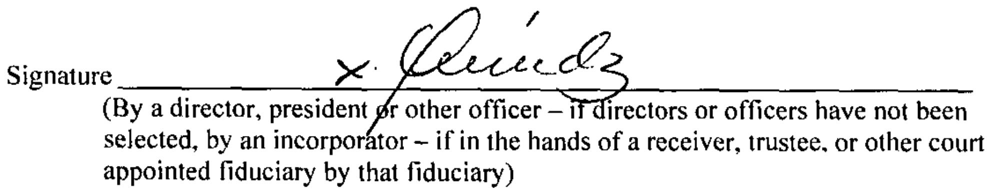
by _______________________________________."
(voting group)

☐ The amendment(s) was/were adopted by the board of directors without shareholder action and shareholder action was not required.

☐ The amendment(s) was/were adopted by the incorporators without shareholder action and shareholder action was not required.

Dated JUNE 24, 2010

Signature



(By a director, president or other officer – if directors or officers have not been selected, by an incorporator – if in the hands of a receiver, trustee, or other court appointed fiduciary by that fiduciary)

OLY M. MENDEZ
(Typed or printed name of person signing)

PRESIDENT
(Title of person signing)

AC# 3763413

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/21/2010	**ARNP 9266471**	**1162617**

The **ADV REG NURSE PRACTITIONER** named below has met all requirements of the laws and rules of the state of Florida.
Expiration Date: **APRIL 30, 2011**

OLY MARIA MENDEZ
4300 ALTON ROAD
MIAMI BEACH, FL 33140
UNITED STATES

QUALIFICATION(S):
NURSE PRACTITIONER

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE AC# 3763413

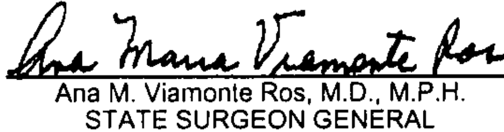
DATE	LICENSE NO.	CONTROL NO.
01/21/2010	ARNP 9266471	1162617

The ADV REG NURSE PRACTITIONER named below has met all requirements of the laws and rules of the state of Florida.
Expiration Date: APRIL 30, 2011

OLY MARIA MENDEZ

QUALIFICATION(S):
Nurse Practitioner

Charlie Crist
GOVERNOR



Ana M. Viamonte Ros, M.D., M.P.H.
STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **APRIL 30, 2011**

Your license number is **ARNP 9266471**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license and click on "**Login**".
6. If you do not know your account ID and password, click on "**Get Login Help**" or call our Customer Contact Center at (850) 488-0595 for assistance.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: ______________________________
LAST FIRST MIDDLE

TO: ______________________________
LAST FIRST MIDDLE

DH 2103. 5/98