

P/4000091384

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP WAIT MAIL

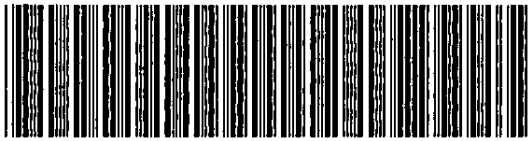
(Business Entity Name)

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TALLAHASSEE, FLORIDA

11/10/14

COVER LETTER

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

SUBJECT: CriticalTRAUMA Practice Centers, Incorporated
(PROPOSED CORPORATE NAME – MUST INCLUDE SUFFIX)

Enclosed are an original and one (1) copy of the articles of incorporation and a check for:

\$70.00
Filing Fee

\$78.75
Filing Fee
& Certificate of Status

\$78.75
Filing Fee
& Certified Copy

\$87.50
Filing Fee,
Certified Copy
& Certificate of
Status

ADDITIONAL COPY REQUIRED

FROM: Alma T. Knight, RN, MBA
Name (Printed or typed)

6003 NW 201 Terrace
Address

Miami Lakes, FL. 3015
City, State & Zip

(305) 467-5229
Daytime Telephone number

ctpracticecenters@att.net
E-mail address: (to be used for future annual report notification)

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)

ARTICLE I NAME CriticalTRAUMA Practice Centers, Incorporated
The name of the corporation shall be:

ARTICLE II PRINCIPAL OFFICE
Principal street address
The Crexcent Business Center
12555 Orange drive, Flamingo Commons
Davie, FL 33330

Mailing address, if different is:
6003 NW 201 Terrace
Miami Lakes, FL
33015

ARTICLE III PURPOSE
The purpose for which the corporation is organized is: (1) the provider of real-time hands-on practice for patient care providers using multilevel patient simulators to teach and reinforce patient care concepts. (2) create and maintain an innovative training environment for health care students (medical, nursing, respiratory, EMT, etc.). (3) Hands-on practice for study groups preparing for exams, certifications, and recertifications. (4) Providing a blended web-based and and on-site classroom sessions.

ARTICLE IV SHARES 100
The number of shares of stock is:

ARTICLE V INITIAL OFFICERS AND/OR DIRECTORS

Name and Title: Alma T. Knight, RN, PDTS
Address: 6003 NW 201 Terrace
Miami Lakes, FL.
33015

Name and Title: _____
Address: _____

Name and Title: _____
Address: _____

Name and Title: _____
Address: _____

Name and Title: _____
Address: _____

Name and Title: _____
Address: _____

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TALLAHASSEE, FLORIDA

Name and Title: _____	Name and Title: _____
Address _____	Address: _____
_____	_____
_____	_____

ARTICLE VI REGISTERED AGENT

The name and Florida street address (P.O. Box NOT acceptable) of the registered agent is:

Name: Alma T. Knight

Address: 6003 NW 201 errace
Miami Lakes, FL. 33015

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ARTICLE VII INCORPORATOR

The name and address of the Incorporator is:

Name: Alma T. Knight,

Address: 6003 NW 201 Terrace
Miami Lakes, FL. 33015

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

Alma T. Knight
 Required Signature/Registered Agent

10/25/2014
 Date

I submit this document and affirm that the facts stated herein are true. I am aware that the 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.

Alma Knight
 Required Signature/Incorporator

10/25/2014
 Date