

PI8000096773

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

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(Business Entity Name)

(Document Number)

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## COVER LETTER

**TO:** Charter Section  
Division of Corporations

**SUBJECT:** CSB HEALTHCARE SOLUTIONS INC

Name of Resulting Florida Profit Corporation

The enclosed Certificate of Conversion, Articles of Incorporation, and fees are submitted to convert an "Other Business Entity" into a "Florida Profit Corporation" in accordance with s. 607.1115, F.S.

Please return all correspondence concerning this matter to:

LUIS PUERTA

Contact Person

Firm/Company

6802 EL DORADO CT

Address

TAMPA, FL 33615

City, State and Zip Code

SANDY@CSBHHEALTHCARESOLUTIONS.BIZ

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

LUIS PUERTO at ( 813 ) 597-4801

Name of Contact Person

Area Code and Daytime Telephone Number

Enclosed is a check for the following amount:

<input checked="" type="checkbox"/> \$105.00 Filing Fees	<input type="checkbox"/> \$113.75 Filing Fees and Certificate of Status	<input type="checkbox"/> \$113.75 Filing Fees and Certified Copy	<input type="checkbox"/> \$122.50 Filing Fees, Certified Copy, and Certificate of Status
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**STREET ADDRESS:**

New Filings Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

**MAILING ADDRESS:**

New Filings Section  
Division of Corporations  
P. O. Box 6327  
Tallahassee, FL 32314

**Certificate of Conversion**  
For  
**"Other Business Entity"**  
Into  
**Florida Profit Corporation**

This Certificate of Conversion **and attached Articles of Incorporation** are submitted to convert the following **"Other Business Entity"** into a **Florida Profit Corporation** in accordance with s. 607.1115, Florida Statutes.

1. The name of the "Other Business Entity" immediately prior to the filing of this Certificate of Conversion is:

CSB HEALTHCARE SOLUTIONS LLC

47-158680

Enter Name of Other Business Entity

2. The "Other Business Entity" is a LLC

(Enter entity type. Example: limited liability company, limited partnership, general partnership, common law or business trust, etc.)

first organized, formed or incorporated under the laws of FLORIDA

(Enter state, or if a non-U.S. entity, the name of the country)

on 11/15/2018

Enter date "Other Business Entity" was first organized, formed or incorporated

3. If the jurisdiction of the "Other Business Entity" was changed, the state or country under the laws of which it is now organized, formed or incorporated:

N/A

4. The name of the Florida Profit Corporation as set forth in the **attached Articles of Incorporation**:

CSB HEALTHCARE SOLUTIONS INC

Enter Name of Florida Profit Corporation

5. If not effective on the date of filing, enter the effective date: 11/15/2018

(The effective date: Cannot be prior to nor more than 90 days after the date this document is filed by the Florida Department of State.)

**Note:** If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as the document's effective date on the Department of State's records.

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CLERK OF THE COURT  
JANUARY 11 2019

Signed this 15TH day of NOVEMBER, 2018.

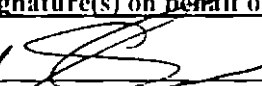
**Required Signature for Florida Profit Corporation:**

Signature of Chairman, ~~Vice Chairman~~, Director, Officer, or, if Directors or Officers have not been selected, an

Incorporator: 

Printed Name: SANDRA PUERTA Title: PRESIDENT

**Required Signature(s) on behalf of Other Business Entity:** [See below for required signature(s).]

Signature: 

Printed Name: SANDRA PUERTA Title: MGR

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

**If Florida General Partnership or Limited Liability Partnership:**

Signature of one General Partner.

**If Florida Limited Partnership or Limited Liability Limited Partnership:**

Signatures of **ALL** General Partners.

**If Florida Limited Liability Company:**

Signature of a Member or Authorized Representative.

**All others:**

Signature of an authorized person.

**Fees:**

Certificate of Conversion:	\$35.00
Fees for Florida Articles of Incorporation:	\$70.00
Certified Copy:	\$8.75 (Optional)
Certificate of Status:	\$8.75 (Optional)

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CLERK OF CIRCUIT COURT  
JUDICIAL CIRCUIT IN AND FOR  
DADE COUNTY, FLORIDA  
67

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

**ARTICLE I    NAME**

The name of the corporation shall be: CSB HEALTHCARE SOLUTIONS INC

**ARTICLE II    PRINCIPAL OFFICE**

The principal place of business/mailling address is:

Principal street address  
6802 EL DORADO CT  
TAMPA, FL 33615

Mailing address, if different is:  
SAME

**ARTICLE III    PURPOSE**

The purpose for which the corporation is organized is:

ANY AND ALL LEGAL BUSINESS

**ARTICLE IV    SHARES**

The number of shares of stock is: 1000

**ARTICLE V    INITIAL OFFICERS AND/OR DIRECTORS**

Name and Title: SANDRA PUERTA  
Address: 6802 EL DORADO CT

Name and Title: PRESIDENT  
Address: TAMPA, FL 33615

Name and Title: LUIS PUERTA  
Address: 6802 EL DORADO CT

Name and Title: VICE PRESIDENT  
Address: TAMPA, FL 33615

Name and Title: \_\_\_\_\_  
Address: \_\_\_\_\_

Name and Title: \_\_\_\_\_  
Address: \_\_\_\_\_

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**ARTICLE VI REGISTERED AGENT**

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

Name: SANDRA PUERTA  
Address: 6802 EL DORADO CT  
TAMPA, FL 33615

**ARTICLE VII INCORPORATOR**

The **name and address** of the Incorporator is:

Name: SANDRA PUERTA  
Address: 6802 EL DORADO CT  
TAMPA, FL 33615

\*\*\*\*\*

*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*

X [Signature]  
Required Signature/Registered Agent

11/15/2018  
Date

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

X [Signature]  
Required Signature/Incorporator

X 11/15/18  
Date

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STATE OF FLORIDA  
TALLAHASSEE, FLORIDA