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(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

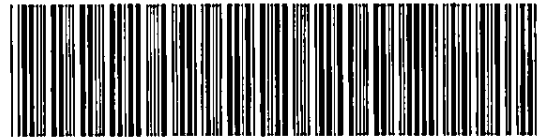
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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**COVER LETTER**

**TO:** Charter Section  
Division of Corporations

**SUBJECT:** Art of Medicine Healthcare, PA

\_\_\_\_\_  
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:

Amanda Phillips

\_\_\_\_\_  
Contact Person

\_\_\_\_\_  
Firm/Company

3225 McLeod Drive, Suite 100

\_\_\_\_\_  
Address

Las Vegas, Nevada 89121

\_\_\_\_\_  
City, State and Zip Code

ra@andersonadvisors.com

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

For further information concerning this matter, please call:

Amanda Phillips

at ( 800 ) 706-4741

\_\_\_\_\_  
Name of Contact Person

\_\_\_\_\_  
Area Code and Daytime Telephone Number

Enclosed is a check for the following amount:

☐ \$105.00 Filing Fees    ☒ \$113.75 Filing Fees and Certificate of Status    ☐ \$113.75 Filing Fees and Certified Copy    ☐ \$122.50 Filing Fees, Certified Copy, and Certificate of Status

**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:

Art of Medicine Healthcare, PC

Enter Name of Other Business Entity

Professional Corporation

2. The "Other Business Entity" is a \_\_\_\_\_  
(Enter entity type. Example: limited liability company, limited partnership,  
general partnership, common law or business trust, etc.)

California

first organized, formed or incorporated under the laws of \_\_\_\_\_  
(Enter state, or if a non-U.S. entity, the name of the country)

on 10/25/2018

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:

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

Art of Medicine Healthcare, PA

Enter Name of Florida Profit Corporation

5. If not effective on the date of filing, enter the effective date: \_\_\_\_\_

(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.

Signed this 6th day of June, 2019.

**Required Signature for Florida Profit Corporation:**

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

Printed Name: Roop Monica Gill Title: PSTD

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

Signature: RMK

Printed Name: Roop Monica Gill Title: PSTD

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)

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS  
19 APR 23 PM 3:03

**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: Art of Medicine Healthcare, PA

**ARTICLE II PRINCIPAL OFFICE**

The principal place of business/mailling address is:

Principal street address  
3225 McLeod Drive, Suite 100

Las Vegas, Nevada 89121

Mailing address, if different is:

**ARTICLE III PURPOSE**

The purpose for which the corporation is organized is:

To provide medical care

**ARTICLE IV SHARES**

The number of shares of stock is: 1000

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

Name and Title: Roop Monica Gill - PSTD

Address: 3225 McLeod Drive, Suite 100

Las Vegas, Nevada 89121

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

Address: \_\_\_\_\_

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

Address: \_\_\_\_\_

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

Address: \_\_\_\_\_

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

Address: \_\_\_\_\_

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

Address: \_\_\_\_\_

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STATE OF NEVADA  
DIVISION OF CORPORATIONS

**ARTICLE VI REGISTERED AGENT**

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

Name: Anderson Registered Agents, Inc.  
Address: 1000 North Washington Blvd.  
Sarasota, Florida 34236

**ARTICLE VII INCORPORATOR**

The name and address of the Incorporator is:

Name: Amanda Phillips  
Address: 3225 McLeod Drive, Suite 100  
Las Vegas, Nevada 89121

\*\*\*\*\*

*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*

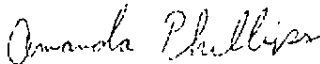


Required Signature/Registered Agent

06/06/2019

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.*



Required Signature/Incorporator

06/06/2019

Date

FILED  
CLERK OF STATE  
DIVISION OF CORPORATIONS  
19 APR 23 PM 3:03