

L22 000 230 625

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP     WAIT     MAIL

(Business Entity Name)

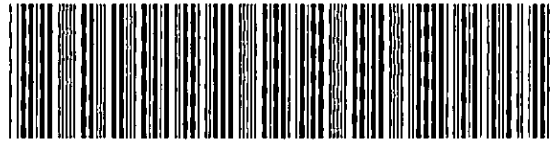
(Document Number)

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

Special Instructions to Filing Officer:

Registered Agent  
Signature

Office Use Only



300421348303

02/02/24--01002--007    \*\*135.00

FILED  
2024 FEB - 1 PM 3:43  
SECRETARY OF STATE  
TALLAHASSEE, FL

RECEIVED  
2024 FEB - 1 PM 4:53  
SECRETARY OF STATE  
TALLAHASSEE, FL 32309-0002

AB

**Advanced Incorporating Service**

1317 California Street  
P.O. Box 20396  
Tallahassee, FL 32316  
Phone: 850-222-CORP  
Fax: 850-575-2724  
Email: wlopez@aisincfl.com  
Website: [www.aisincfl.com](http://www.aisincfl.com)

NAME OF ENTITY	FOR OFFICE USE ONLY
Omni Integrative Medicine Orlando PLLC	

**PICK ONE:**

\_\_\_ CERTIFIED COPY    XX PHOTOCOPY    \_\_\_ C.U.S.

**FILING:**

\_\_\_ CORPORATION    \_\_\_ LLC    \_\_\_ LIMITED PARTNERSHIP    \_\_\_ GENERAL PARTNERSHIP

\_\_\_ FICTITIOUS NAME    \_\_\_ SERVICEMARK/TRADEMARK    \_\_\_ AMENDMENT

\_\_\_ FOREIGN QUALIFICATION    \_\_\_ JUDGMENT LIEN

XX OTHER Registered Agent Resignation

**RETRIEVAL:**

\_\_\_ GOOD STANDING CERT/C.U.S.    \_\_\_ CERTIFIED COPY    \_\_\_ PHOTOCOPY  
Of \_\_\_\_\_

**APOSTILLE/NOTARY CERTIFICATION REQUEST:**

Country \_\_\_\_\_

Amount of Documents \_\_\_\_\_

**DATE** 2/1/24    **TIME** \_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_

# STATEMENT OF RESIGNATION OF REGISTERED AGENT FOR A LIMITED LIABILITY COMPANY

Pursuant to the provisions of section 605.0115, Florida Statutes, the undersigned,

Advanced Filing and Retrieval Services, Inc. \_\_\_\_\_, hereby resigns as

Name of Registered Agent

Registered Agent for OMNI INTEGRATIVE MEDICINE OF ORLANDO PLLC

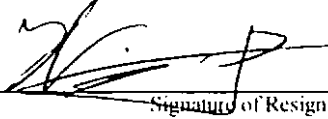
Name of Limited Liability Company

1.22000230625

Document Number, if known

A copy of this resignation was mailed to the above listed limited liability company at its last known address.

The agency is terminated and the office discontinued on the 31st day after the date on which this statement is filed.



Signature of Resigning Agent

If signing on behalf of an entity:

Weimar Lopez

Typed or Printed Name

Secretary

Capacity

### FILING FEES:

\$ 85.00 Active limited liability company  
\$ 25.00 Administratively dissolved/ voluntarily dissolved/  
withdrawn limited liability company

FILED  
2024 FEB - 1 PM 3:44  
TALLAHASSEE  
SECRETARY

Make checks payable to Florida Department of State and mail to:  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314



FLORIDA DEPARTMENT OF STATE  
Division of Corporations

February 2, 2024

ADVANCED INCORPORATING SERVICE

SUBJECT: OMNI INTEGRATIVE MEDICINE OF ORLANDO PLLC  
Ref. Number: L22000230625

We have received your document for OMNI INTEGRATIVE MEDICINE OF ORLANDO PLLC and your check(s) totaling \$195.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

The registered agent must sign accepting the designation.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6050.

Anissa Butler  
Regulatory Specialist II

Letter Number: 824A00002297

*Corrected  
keep original take date  
Thanks*

RECEIVED  
2024 FEB -5 PM 2:50  
TALLAHASSEE, FLORIDA