

122000515758

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

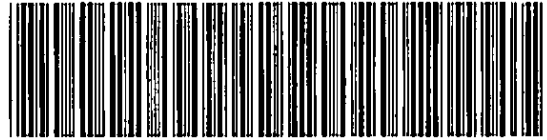
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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

COVER LETTER

TO: Registration Section
Division of Corporations

Amplified Vitality Wellness Clinic, LLC

SUBJECT: _____
Name of Limited Liability Company

Dear Sir or Madam:

The enclosed Statement of Correction and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Christopher LaCross, MD

Name of Person

Amplified Vitality Wellness Clinic, LLC

Firm/Company

312 NE 26th St

Address

Wilton Manors, FL 33305

City/State and Zip Code

topherlacrossmd@gmail.com

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

For further information concerning this matter, please call:

Christopher LaCross, MD

603

303-3660

at ()

Name of Person

Area Code

Daytime Telephone Number

Mailing Address:

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

Street Address:

Registration Section
Division of Corporations
The Centre of Tallahassee
2415 N. Monroe Street, Suite 810
Tallahassee, FL 32303

Enclosed is a check for the following amount:

- ☐ \$25 Filing Fee ☐ \$30 Filing Fee & Certificate of Status ☐ \$55 Filing Fee & Certified Copy ☒ \$60 Filing Fee, Certificate of Status & Certified Copy

**STATEMENT OF CORRECTION
FOR
FLORIDA OR FOREIGN LIMITED LIABILITY COMPANY**

Pursuant to section 605.0209, F.S., this document is being submitted to correct a previously filed document.
Amplified Vitality Welless Clinic, LLC

FIRST: The name of the limited liability company is: _____

1.22000515758

SECOND: The Florida Document number of the limited liability company is: _____
1.22000515758

THIRD: Document to be corrected is: _____

(CHECK THE APPROPRIATE BOX AND COMPLETE THE APPLICABLE STATEMENT)

☒ Contains an incorrect statement. The incorrect statement, the reason the statement is incorrect, and the corrected statement are as follows:

NAME OF CLINIC NEEDS TO HAVE AN "N" IN WELLNESS, PLEASE MODIFY TO:

AMPLIFIED VITALITY WELLNESS CLINIC, LLC

OR

☒ Was defectively signed. The manner in which the document was defectively signed and the appropriate correction are as follows:

OR

☒ The electronic transmission of the record was defective.

Signature of Authorized Representative

DECEMBER 12TH, 2022

Date

Signature of new registered agent, if applicable : (NOTE: if correcting the registered agent, the new registered agent must sign accepting the designation).

New Registered Agent's Signature, if changing Registered Agent:

I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent as provided for in Chapter 605, F.S. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.

Registered Agent's Signature

Filing Fee: \$25.00
Certified Copy: \$30.00 (optional)

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