



COMMONWEALTH OF KENTUCKY
MICHAEL G. ADAMS, SECRETARY OF STATE

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Michael G. Adams
Kentucky Secretary of State
 Received and Filed:
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Division of Business Filings

P.O. Box 718
 Frankfort, KY 40602
 (502) 564-3490
www.sos.ky.gov

Certificate of Authority
 (Foreign Business Entity)

Pursuant to the provisions of KRS 14A – 030 the undersigned hereby applies for authority to transact business in Kentucky on behalf of the entity named below and, for that purpose, submits the following statements:

1. The entity is a: ☐ profit corporation ☐ nonprofit corporation ☐ professional limited liability company
☐ business trust ☐ limited liability company ☐ statutory trust
☐ limited partnership ☐ ltd cooperative association ☐ other
☐ non-profit llc ☒ professional service corporation

2. The name of the entity is Mobile Care Physicians Group, P.C.
 (The name must be identical to the name on record with the Secretary of State.)

3. The name of the entity to be used in Kentucky is (if applicable): Mobile Care Physicians Group, P.S.C.
 (Only provide if "real name" is unavailable for use; otherwise, leave blank.)

4. The state or country under whose law the entity is organized is Michigan

5. The date of organization is October 11, 2021 and the period of duration is _____
 (If left blank, duration is considered perpetual.)

6. The mailing address of the entity's principal office is
312 S. 4th Street, Suite 700 Louisville KY 40202
Street Address **City** **State** **Zip Code**

7. The street address of the entity's registered office in Kentucky is
421 West Main St. Frankfort KY 40601
Street Address (No P.O. Box Numbers) **City** **State** **Zip Code**

and the name of the registered agent at that office is Corporation Service Company

8. The names and business addresses of the entity's representatives (secretary, officers and directors, managers, trustees or general partners):

Name (Pres., Sec., Treas., Director)	Street or P.O. Box	City	State	Zip Code
Sajad Zalzal, M.D.	835 Mason St., Set A250	Dearborn	MI	48124
Name	Street or P.O. Box	City	State	Zip Code
Name	Street or P.O. Box	City	State	Zip Code
Name	Street or P.O. Box	City	State	Zip Code

9. If a professional service corporation, all the individual shareholders, not less than one half (1/2) of the directors, and all of the officers other than the secretary and treasurer are licensed in one or more states or territories of the United States or District of Columbia to render a professional service described in the statement of purposes of the corporation.

10. I certify that, as of the date of filing this application, the above-named entity validly exists under the laws of the jurisdiction of its formation.

11. If a limited partnership, it elects to be a limited liability limited partnership. Check the box if applicable: ☐

12. If a limited liability company, check box if manager-managed: ☐

13. This application will be effective upon filing.

Signature of Authorized Representative	Printed Name & Title	Date
<u>Sajad Zalzal M.D.</u>	<u>Sajad Zalzal, M.D., President</u>	<u>7/30/2022</u>

I, Corporation Service Company, consent to serve as the registered agent on behalf of the business entity.
Type/Print Name of Registered Agent

Signature of Registered Agent	Printed Name	Title	Date
<u>Richard</u>	<u>Corporation Service Company</u>	<u>Asst. Secretary</u>	<u>8/2/2022</u>