2004 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Mar 15, 2004 8:00 am
Secretary of State
03-04-2004 90072 005 ****50.00

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1. Entity Name
TALLAHASSEE NEUROSURGERY PAIN MANAGEMENT, LLC

34001579

Principal Place of Business	Mailing Address
1401 CENTERVILLE ROAD, SUITE 300 TALLAHASSEE, FL 32308	1401 CENTERVILLE ROAD, SUITE 300 TALLAHASSEE, FL 32308

02262004 Chg-LLC CR2E083 (10/03)

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 20-0307088 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $5.00 Additional Fee Required

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
CUFFE, MARK J M.D. 1401 CENTERVILLE ROAD, SUITE 300 TALLAHASSEE, FL 32308	Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE ______________________ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

Filing Fee is $50.00
Due by May 1, 2004

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR CUFFE, MARK J M.D. 1401 CENTERVILLE ROAD, SUITE 300 TALLAHASSEE, FL 32308	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Add
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR RUMANA, CHRISTOPHER S M.D. 1401 CENTERVILLE ROAD, SUITE 300 TALLAHASSEE, FL 32308	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Add
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Add
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Add
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Add

11. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE: Mark J. Cuffe MD Mark J. Cuffe, MD 2-26-04 (850) 877-6054
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #