2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Jun 29, 2005 8:00 am
Secretary of State

04-28-2005 90049 001 *3,150.00

DOCUMENT # L04000020837

1. Entity Name
OBSTETRICS AND GYNECOLOGY ASSOCIATES OF KENDALL, LLC

30009820

Principal Place of Business	Mailing Address
3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741	3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741

04202005 Chg-LLC CR2E083 (10/03)

2. Principal Place of Business		3. Mailing Address	
9545 N. Kendall Dr.			
Suite, Apt. #, etc.: Ste. 103		Suite, Apt. #, etc.	
City & State: Miami, FL		City & State	
Zip: 33176	Country: U.S.A.	Zip	Country

4. FEI Number: 54-2129332 ☐ 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
YELEN, MITCHELL A 3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741	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 ______________________________
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

Filing Fee is $50.00
Due by May 1, 2005

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE: MANAGER NAME: Robert Boyett, MD STREET ADDRESS: 8955 SW 87 Court, #214 CITY-ST-ZIP: Miami, FL 33176	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
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TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition

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: Mitchell A. Yelen 04/25/05 305-858-5800
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #

Mitchell A. Yelen

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5/31/05                    CORPORATE DETAIL RECORD SCREEN                      2:00 PM
NUM: L04000020837 ST:FL ACTIVE/FL LIM LIAB     FLD: 03/11/2004
TOTAL CONTR: 0.00
NAME      : OBSTETRICS AND GYNECOLOGY ASSOCIATES OF KENDALL, LLC
PRINCIPAL: 3225 AVIATION AVE., SUITE 500
ADDRESS     MIAMI, FL 33133-4741
RA NAME   : YELEN, MITCHELL A
RA ADDR   : 3225 AVIATION AVE., SUITE 500
            MIAMI, FL 33133-4741
ANN REP   : * NONE FILED *
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ATTACHMENT 30009820
L04000020837

1. MENU

ENTER SELECTION AND CR:

STATE OF FLORIDA
OFFICE OF THE COMPTROLLER ATTACHMENT 30009820
APPLICATION FOR REFUND #L04000020837

Section 215.26, Florida Statutes, states in part: "Applications for refunds as provided in this section shall be filed with the Comptroller, except as otherwise provided herein, within 3 years after the right to such refund shall have accrued else such right shall be barred." Three years is generally interpreted as meaning three years from the date of payment into the State Treasury. The Comptroller has delegated the authority to accept applications for refund to the unit of State government which initially collected the money.

Pursuant to the provisions of Rule 3A-44.020, Florida Administrative Code, and Section 215.26, Florida Statutes, or Section _________*, Florida Statutes, I hereby apply for a refund of moneys I paid into the State Treasury, which are subject to refund. The following information is submitted to substantiate the claim.

THE INFORMATION IN THIS BOX WILL BE USED TO WRITE AND MAIL YOUR REFUND CHECK. PLEASE TYPE OR PRINT LEGIBLY.

Name: ______________________ EIN or SS#: ______________

Address: ______________________________________

____

Amount: ____________ Date Paid: ______________

Reason for Claim: ______________________________

____

____

Certified true and correct this _______ day of ________________, ____________.

Signature ______________________________

* Must be completed if authority is other than Section 215.26, Florida Statutes.

Do Not Write in This Box - For Agency Use Only

Amount of recommended refund $ 50.00

The amount requested above was originally deposited into the State Treasury, as a part of the funds deposited on

State Treasurer's Receipt No. 90049-01 *dated* 4.28.05

NAME OF ACCOUNT: 4510100013245300100000010000000

Statutory Authority for Collection 608.0452

It is requested that payment be made from the following account

NAME OF ACCOUNT: 4510100013245300100000220020000