


FILED
Apr 07, 2008 8:00 am
Secretary of State

03-10-2008 90336 025 ***138.75

2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

DOCUMENT # L07000049975			
1. Entity Name CIRCLE OF HEALTH FAMILY PRACTICE, LLC			
Principal Place of Business 4869 PALM COAST PARKWAY NW SUITE 5 PALM COAST, FL 32137 US		Mailing Address 4869 PALM COAST PARKWAY NW SUITE 5 PALM COAST, FL 32137 US	
2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country
4. FEI Number 26-0142684		Applied For Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/>		\$5.00 Additional Fee Required	
6. Name and Address of Current Registered Agent DOLINKY, ADRIENNE 4869 PALM COAST PARKWAY NW SUITE 5 PALM COAST, FL 32137		7. Name and Address of New Registered Agent 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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when re-registering)</small>			
FILE NOW!!! FEE IS \$138.75 After May 1, 2008 Fee will be \$538.75		Make check payable to Florida Department of State	
9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR DOLINKY, ADRIENNE 4869 PALM COAST PARKWAY NW, SUITE 5 PALM COAST, FL 32137 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: <u>Adrienne Dolink</u>		3/3/08 326-447-1803	
<small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE</small>		<small>Date Daytime Phone #</small>	

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