

**2015 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L07000021354

**Entity Name:** SOUTHERN VITREORETINAL ASSOCIATES, P.L.

**Current Principal Place of Business:**

2439 CARE DRIVE  
TALLAHASSEE, FL 32308-4580

**Current Mailing Address:**

2439 CARE DRIVE  
TALLAHASSEE, FL 32308-4580

**FEI Number:** 20-8515285

**Certificate of Status Desired:** No

**Name and Address of Current Registered Agent:**

PIERCE, ROBERT A  
123 SOUTH CALHOUN STREET  
TALLAHASSEE, FL 32301-1517 US

*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.*

**SIGNATURE:**

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**Authorized Person(s) Detail :**

Title MGRM  
Name BROOKS, H. LOGAN M.D.  
Address 2439 CARE DRIVE  
City-State-Zip: TALLAHASSEE FL 32308-4580

Title MGRM  
Name STEINMETZ, ROBERT LM.D.  
Address 2439 CARE DRIVE  
City-State-Zip: TALLAHASSEE FL 32308-4580

Title MGRM  
Name NEWELL, CHARLES KM.D.  
Address 2439 CARE DRIVE  
City-State-Zip: TALLAHASSEE FL 32308-4580

Title MGRM  
Name WILLINGHAM, CHRISTOPHER LM.D.  
Address 2439 CARE DRIVE  
City-State-Zip: TALLAHASSEE FL 32308

Title MGRM  
Name ASHMORE, EMILY DM.D.  
Address 2439 CARE DRIVE  
City-State-Zip: TALLAHASSEE FL 32308

*I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 605, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.*

**SIGNATURE:** ROBERT STEINMETZ

**MGRM**

**02/23/2015**

\_\_\_\_\_  
Electronic Signature of Signing Authorized Person(s) Detail

\_\_\_\_\_  
Date