

**2024 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L17000102360

**Entity Name:** COX CHIROPRACTIC CARE LLC

**Current Principal Place of Business:**

1430 SW SAINT LUCIE WEST BLVD  
103  
PORT ST LUCIE, FL 34986

**Current Mailing Address:**

1430 SW SAINT LUCIE WEST BLVD  
103  
PORT ST LUCIE, FL 34986 US

**FEI Number:** 82-1444375

**Certificate of Status Desired:** No

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

COX, CLIFTON W  
1430 SW SAINT LUCIE WEST BLVD  
103  
PORT ST LUCIE, FL 34986 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 AR  
Name COX, CLIFTON W DR.  
Address 2172 SE ELMHURST RD  
City-State-Zip: PORT ST LUCIE FL 34952

Title AUTHORIZED MEMBER  
Name COX, PATRICIA  
Address 1430 SW SAINT LUCIE WEST BLVD  
103  
City-State-Zip: PORT ST LUCIE FL 34986

*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:** CLIFTON COX

**REGISTERED AGENT**

**01/17/2024**

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

\_\_\_\_\_  
Date