

**2023 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L21000206252

**Entity Name:** CLE HEALTH CARE SERVICES LLC

**Current Principal Place of Business:**

205 MORSE AVE  
INTERLACHEN, FL 32148

**Current Mailing Address:**

205 MORSE AVE  
INTERLACHEN, FL 32148

**FEI Number:** 86-3832177

**Certificate of Status Desired:** No

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

STUMBO, WANDA  
755 HWY 17 SO  
SAN MATEO, FL 32187 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           | MGR                  | Title           | AUTHORIZED REPRESENTATIVE |
| Name            | EMANUEL, CHARLENE    | Name            | EMANUEL, TAVARES          |
| Address         | 205 MORSE AVE        | Address         | 205 MORSE AVE             |
| City-State-Zip: | INTERLACHEN FL 32148 | City-State-Zip: | INTERLACHEN FL 32148      |

*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:** CHARLENE EMANUEL

**OWNER**

**04/28/2023**

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

\_\_\_\_\_  
Date