


2004 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
May 03, 2004 8:00 am
Secretary of State

05-03-2004 90129 029 ****50.00

DOCUMENT # L00000000278	
1. Entity Name SOUTH FLORIDA INPATIENT MEDICAL SPECIALIST, P.L.	

Principal Place of Business 5840 14TH AVE., N.W. NAPLES, FL 34119	Mailing Address PO BOX 8523 NAPLES, FL 34101
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24063422



2. Principal Place of Business 5840 SHADY OAKS LANE Suite, Apt. #, etc.		3. Mailing Address Suite, Apt. #, etc.	
City & State NAPLES, FL		City & State	
Zip 34119	Country COLLIER	Zip	Country

01162004 Chg-LLC CR2E083 (10/03)

4. FEI Number 59-3615495	Applied For <input type="checkbox"/> Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	\$5.00 Additional Fee Required
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6. Name and Address of Current Registered Agent	
MCARDLE, MICHAEL W ESQ. 1112 GOODLETTER RD STE 204 NAPLES, FL 34102	

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 _____ (NOTE: Registered Agent's signature required when reinstating) _____ **DATE** _____

**Filing Fee is \$50.00
Due by May 1, 2004**

**Make check payable to
Florida Department of State**

9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR OTTO, RICHARD D M.D. 5840 14TH AVE. N.W. NAPLES, FL 34119 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition 5840 SHADY OAKS LANE NAPLES, FL 34119
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
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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: X [Signature]
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

X 4-29-04 239-554-9221
Date Daytime Phone #