


# 2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

**FILED**  
**Apr 23, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # L01000000744</b> 1. Entity Name HAND AND PERIPHERAL NERVE SPECIALISTS, P.L.	
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Principal Place of Business 8940 N. KENDALL DRIVE #904 E MIAMI, FL 33176	Mailing Address P.O. BOX 43-0942 MIAMI, FL 33243
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DO NOT WRITE IN THIS SPACE

04132005 No Chg-LLC	CR2E083 (10/03)
4. FEI Number 65-0673357	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	<b>\$5.00</b> Additional Fee Required

6. Name and Address of Current Registered Agent  JOHN A.I. GROSSMAN, M.D., F.A.C.S., P.A. 8940 N. KENDALL DRIVE #904 E MIAMI, FL 33176	<p style="font-size: 24px; font-weight: bold;">DO NOT WRITE IN THIS SPACE</p>
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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 signature required when reinstating) \_\_\_\_\_ DATE \_\_\_\_\_


Filing Fee is \$50.00  
Due by May 1, 2005

9. MANAGING MEMBERS/MANAGERS	
TITLE	MGRM
NAME	GROSSMAN, JOHN A
STREET ADDRESS	8940 N. KENDALL DRIVE -SUITE 904E
CITY-ST-ZIP	MIAMI, FL 33176
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

00000326283  
04/23/05-80051-001 50.00

DO NOT WRITE  
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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:  \_\_\_\_\_

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE \_\_\_\_\_ Date \_\_\_\_\_ Daytime Phone # \_\_\_\_\_