2004 LIMITED LIABILITY COMPANY ANNUAL REPORT (AR)

FILED
Mar 02, 2004 08:00 AM
Secretary of State

DOCUMENT # L01000008040

1. Entity Name

NEUROLOGICAL CARE CENTER, LLC

Principal Place of Business	Mailing Address
2736 UNIVERSITY BLVD. WEST JACKSONVILLE FL 32217	2736 UNIVERSITY BLVD. WEST JACKSONVILLE FL 32217

MOORE CR2E083 (11/03)

2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. FEI Number 59-3725058 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$5.00** Additional Fee Required

6. Name and Address of Current Registered Agent

GAMA, CARLOS H MD
2736 UNIVERSITY BLVD. WEST
JACKSONVILLE FL 32217

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 ______________________________ DATE
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS $50.00
Make Check Payable to Florida Department of State
Due By May 1, 2004

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE	MGRD	☐ Delete	TITLE		☐ Change ☐ Addition
NAME	GAMA, CARLOS H		NAME	U00000073600	
STREET ADDRESS	2736 UNIVERSITY BLVD W #3		STREET ADDRESS	03/02/04-80043-009 50.00	
CITY-ST-ZIP	JACKSONVILLE FL 32217		CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
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TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		

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] 2/27/04 904 703 8596
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #