


**2007 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
Apr 20, 2007 08:00 AM
Secretary of State

DOCUMENT # L01000008040 1. Entity Name NEUROLOGICAL CARE CENTER, LLC	
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Principal Place of Business
2736 UNIVERSITY BLVD. WEST
JACKSONVILLE, FL 32217

Mailing Address
2736 UNIVERSITY BLVD. WEST
JACKSONVILLE, FL 32217



04132007 No Chg-LLC

CR2E083 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-3725058	Applied For Not Applicable
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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

**DO NOT WRITE
IN THIS SPACE**

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 _____

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

**Filing Fee is \$50.00
Due by May 1, 2007**

U000000720549
05/01/07-80109-004 55.00

9. MANAGING MEMBERS/MANAGERS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM GAMA, CARLOS H 2736 UNIVERSITY BLVD W #3 JACKSONVILLE, FL 32217
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**DO NOT WRITE
IN THIS SPACE**

11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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

4/13/07

Date

Daytime Phone #