2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 30, 2002 8:00 am
Secretary of State
05-07-2002 90383 022 ****50.00

DOCUMENT # L01000010513

1. Entity Name
TRICOUNTY ANESTHESIA, LLC

Principal Place of Business	Mailing Address
250 COUNTY ROAD 427 SUITE 114 LONGWOOD FL 32750	P.O. BOX 521150 LONGWOOD FL 32752-1150

[redacted]

DO NOT WRITE IN THIS SPACE

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 52-2328490 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent

AVIDON, G STEVEN M.D.
250 COUNTY ROAD 427
SUITE 114
LONGWOOD FL 32750

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.

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

FILE NOW!!! FEE IS $50.00
Make Check Payable to Department of State
Due By May 1, 2002

9.	MANAGING MEMBERS/MANAGERS	10.	ADDITIONS/CHANGES
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM ☐ Delete TRICOUNTY ANESTHESIA MANAGEMENT, LLC 250 COUNTY ROAD 427 LONGWOOD FL 32750	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition

CR2E083 (9/01)

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