7/7/2003-90074-008-$50.00-$50.00

FILED
03 JUL 21 AM 10:48
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

# LIMITED LIABILITY COMPANY
# UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # L01000010513

1. Entity Name

TRICOUNTY ANESTHESIA, LLC

DO NOT WRITE IN THIS SPACE

| 2. Principal Place of Business | 3. Mailing Address |
|---|---|
| 210 South Park | 210 South Park |
| Suite, Apt. #, etc. 102 | Suite, Apt. #, etc. 102 |
| City & State Sanford, Florida | City & State Sanford, Florida |
| Zip 32771 Country USA | Zip 32771 Country USA |

DO NOT WRITE IN THIS SPACE

4. FEI Number 52-2328490 ☐ Applied For ☐ Not Applicable

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

DO NOT WRITE IN THIS SPACE

7. Name and Address of Current Registered Agent

Name: William P. Weatherford, Jr.

Street Address (P.O. Box Number is Not Acceptable)

1150 Louisiana Avenue, Suite 4

City: Winter Park FL Zip Code: 32789

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: 7/18/03

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

FEE IS $50.00
Make Check Payable to Florida Department of State
DUE BY MAY 1

9. MANAGING MEMBERS / MANAGERS

| | |
|---|---|
| TITLE | MGR |
| NAME | TriCounty Anesthesia Management, LLC |
| STREET ADDRESS | 201 South Park, Suite 102 |
| CITY-ST-ZIP | Sanford, Florida 32771 |

TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP

DO NOT WRITE IN THIS SPACE

CR2E083B (12/02)

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: Arturo F. Espanola, MD 6/26/03

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