

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 29, 2002 8:00 am
Secretary of State

05-06-2002 90011 021 ****50.00

DOCUMENT # L010000121981

1. Entity Name

TRICOUNTY ANESTHESIA-EUSTIS CHARTERED

Principal Place of Business

Mailing Address

250 COUNTY ROAD 427, SUITE 114
LONGWOOD FL 32750POST OFFICE BOX 521150
LONGWOOD FL 32752-1150

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

52-2332999

Applied For

Not Applicable

5. Certificate of Status Desired

☐**\$5.00 Additional
Fee Required**

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

TRICOUNTY ANESTHESIA, LLC
250 COUNTY ROAD 427, SUITE 114
LONGWOOD FL 32750

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

9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM TRICOUNTY ANESTHESIA, LLC 250 COUNTY ROAD 427, SUITE 114 LONGWOOD FL 32750 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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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, MANAGER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

CR2E083 (9/01)