2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 21, 2002 8:00 am
Secretary of State
01-16-2002 90258 031 ****50.00

DOCUMENT # L01000017775

1. Entity Name
KATHY STIGAR C.R.N.A. LLC

Principal Place of Business	Mailing Address
27031 HARBOR DR. BONITA SPRINGS FL 34135 US	27031 HARBOR DR. BONITA SPRINGS FL 34135 US

ว บ ข ! 43678

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 — ✓ 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
STIGAR, KATHY R CRNA 27031 HARBOR DR. BONITA SPRINGS FL 34135	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 (error - KS)		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	~~CRNA/OWNER~~ MgMr Kathy Stigar 27031 Harbor Dr Bonita Springs FL 34135 ☐ Delete	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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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: Kathy R. Stigar CRNA — 01/07/02 — 941 495-9917
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #

lease assign EIN and fax back to me a.s.a.p. Attachment
Thanks, Kathleen

Form **SS-4**
(Rev. April 2000)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, certain individuals, and others. See instructions.)

▶ Keep a copy for your records.

EIN [redacted]
OMB No. 1545-0003

Please type or print clearly.

1 Name of applicant (legal name) (see instructions)
Kathleen Stigar CRNA (Letter No: 801A000573(68)

2 Trade name of business (if different from name on line 1)

3 Executor, trustee, "care of" name
Kathleen Stigar

4a Mailing address (street address) (room, apt., or suite no.)
27031 HARBOR DR.

5a Business address (if different from address on lines 4a and 4b)

4b City, state, and ZIP code
BONITA SPRINGS FL 34135

5b City, state, and ZIP code

6 County and state where principal business is located
Lee, FL

7 Name of principal officer, general partner, grantor, owner, or trustor—SSN or ITIN may be required (see instructions) ▶ 265-48-4207
KATHLEEN STIGAR

8a Type of entity (Check only one box.) (see instructions)
Caution: *If applicant is a limited liability company, see the instructions for line 8a.*

- ☐ Sole proprietor (SSN) _____
- ☐ Partnership
- ☐ REMIC
- ☐ State/local government
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶ _____
- ☐ Other (specify) ▶
- ☐ Personal service corp.
- ☐ National Guard
- ☐ Farmers' cooperative
- ☐ Estate (SSN of decedent) _____
- ☐ Plan administrator (SSN) _____
- ☒ Other corporation (specify) ▶ LLC
- ☐ Trust
- ☐ Federal government/military
- (enter GEN if applicable) _____

8b If a corporation, name the state or foreign country (if applicable) where incorporated — State: FL — Foreign country:

9 Reason for applying (Check only one box.) (see instructions)
- ☒ Started new business (specify type) ▶ ANESTHESIA SERVICES
- ☐ Hired employees (Check the box and see line 12.)
- ☐ Created a pension plan (specify type) ▶
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Other (specify) ▶

10 Date business started or acquired (month, day, year) (see instructions)
JAN 1 2001

11 Closing month of accounting year (see instructions)
December

12 First date wages or annuities were paid or will be paid (month, day, year). Note: *If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)* ▶ 01/15/2001

13 Highest number of employees expected in the next 12 months. Note: *If the applicant does not expect to have any employees during the period, enter -0-. (see instructions)* ▶

Nonagricultural	Agricultural	Household
0	0	0

14 Principal activity (see instructions) ▶ ANESTHESIA MEDICAL SERVICES

15 Is the principal business activity manufacturing? ☐ Yes ☒ No
If "Yes," principal product and raw material used ▶

16 To whom are most of the products or services sold? Please check one box.
- ☐ Public (retail)
- ☐ Other (specify) ▶
- ☐ Business (wholesale)
- ☒ N/A

17a Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☐ No
Note: *If "Yes," please complete lines 17b and 17c.*

17b If you checked "Yes" on line 17a, give applicant's legal name and trade name shown on prior application, if different from line 1 or 2 above.
Legal name ▶ Trade name ▶

17c Approximate date when and city and state where the application was filed. Enter previous employer identification number if known.
Approximate date when filed (mo., day, year) | City and state where filed | Previous EIN

FAX: 941 949-1035

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Name and title (Please type or print clearly.) ▶ Kathleen Stigar CRNA, President

Business telephone number (include area code): (941) 495-9917

Fax telephone number (include area code): (941) 949-1035

Signature ▶ Kathleen Stigar CRNA, President

Date ▶ 11/27/01

Note: *Do not write below this line. For official use only.*

Please leave blank ▶	Geo.	Ind.	Class	Size	Reason for applying