2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Sep 03, 2002 8:00 am
Secretary of State
05-15-2002 90136 018 ****50.00
09-03-2002 90115 026 ****50.00

DOCUMENT # L01000019662

1. Entity Name
TRICOUNTY ANESTHESIA-VOLUSIA CHARTERED

Principal Place of Business	Mailing Address
P.O. BOX 521150 LONGWOOD FL 32752-1150	P.O. BOX 521150 LONGWOOD FL 32752-1150

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 26-0006811 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent

TRICOUNTY ANESTHESIA, LLC
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. 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

FILE NOW!!! FEE IS $50.00
Make Check Payable to Department of State
Due By September 25, 2002

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	☐ 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 (4/02)

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: Michael A Binford MD
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #