

**2008 LIMITED LIABILITY COMPANY  
ANNUAL REPORT**

**FILED**  
**Apr 16, 2008 08:00 A**  
**Secretary of State**

**DOCUMENT # L01000021981**

1. Entity Name  
**DONALD D. STODDARD, M.D., LLC**



Principal Place of Business  
**270 HUMMINGBIRD LANE  
LONGWOOD, FL 32779**

Mailing Address  
**P.O. BOX 3060  
C/O SCEARCE, SATCHER & JUNG P.A.  
WINTER PARK, FL 32790-3060**



01032008 No Chg-LLC

CR2E083 (12/07)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number <b>22-3850206</b>	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	<b>\$5.00</b> Additional Fee Required

**6. Name and Address of Current Registered Agent**

**STODDARD, DONALD D M.D.  
270 HUMMINGBIRD LANE  
LONGWOOD, FL 32779**

**DO NOT WRITE  
IN THIS SPACE**

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 \$138.75  
After May 1, 2008 Fee will be \$538.75**

U000000901166  
04/29/08-80057-007 138.75

**9. MANAGING MEMBERS/MANAGERS**

TITLE NAME STREET ADDRESS CITY - ST - ZIP	<b>MGRM STODDARD, DONALD DMD 270 HUMMINGBIRD LANE LONGWOOD, FL 32779</b>
TITLE NAME STREET ADDRESS CITY - ST - ZIP	
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IN THIS SPACE**

11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

**Donald D. Stoddard, MD 4/14/08 321-277-5990**