

2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Mar 03, 2008 8:00 am
Secretary of State

03-03-2008 90401 047 ***138.75

DOCUMENT # L02000004303		
1. Entity Name A. GIROUARD, LLC		

Principal Place of Business ONE ST. JOHNS MEDICAL PARK DRIVE SUITE A ST. AUGUSTINE, FL 32086	Mailing Address ONE ST. JOHNS MEDICAL PARK DRIVE SUITE A ST. AUGUSTINE, FL 32086
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2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

02182008 Chg-LLC CR2E083 (12/06)

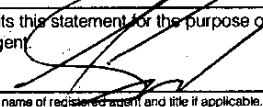
4. FEI Number
02-0552646

Applied For
☐ Not Applicable

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

6. Name and Address of Current Registered Agent	
GIROUARD, ALLAIN ONE ST. JOHNS MEDICAL PARK DRIVE SUITE A ST. AUGUSTINE, FL 32086	

7. Name and Address of New Registered Agent	
Name Same agent / new address	
Street Address (P.O. Box Number is Not Acceptable) 1740 TREE BLVD #114	
City ST AUGUSTINE	FL Zip Code 32084

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 2/18/08

9. MANAGING MEMBERS/MANAGERS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PST. GIROUARD, ALLAIN ONE ST. JOHNS MEDICAL PARK DR., SUITE A ST. AUGUSTINE, FL 32086

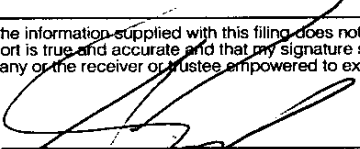
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR GIROUARD, ALLAIN ONE ST. JOHNS MEDICAL PARK DR., SUITE A ST. AUGUSTINE, FL 32086
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete
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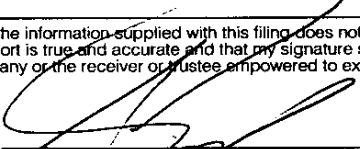
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete
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11. I hereby certify that the information supplied with this filing does not qualify for the exemptions 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: 	DATE 2/18/08

10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☒ Change ☐ Addition 1740 TREE BLVD SUITE #114 ST AUGUSTINE, FL 32084
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition

FILE NOW!!! FEE IS \$138.75 After May 1, 2008 Fee will be \$538.75	Make check payable to Florida Department of State
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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: 	DATE 2/18/08

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

ATTACHMENT

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS		FILED 07 JUL -2 PM 2:17 SECRETARY OF STATE TALLAHASSEE, FLORIDA # 60011904																	
DOCUMENT # L 02000004303																					
1. Limited Liability Company's Name A. GIROUARD LLC																					
2. Principal Office Address - No P.O. Box # 1ST JOHNS MEDICAL PARK Suite, Apt. #, etc. Drive Suite A City & State ST Augustine FL Zip Country 32086 USA		3. Mailing Office Address Same Suite, Apt. #, etc. City & State Zip Country		4. State/Country of Formation FLORIDA / USA 5. Date Organized or Qualified To Do Business in Florida Feb. 22nd, 2002 6. SE Number 020552646 7. CERTIFICATE OF STATUS DES NO																	
8. Name and Address of Current Registered Agent Name ALLAIN GIROUARD Street Address (P.O. Box Number is Not Acceptable) 1ST JOHNS MEDICAL PARK DR. Suite, Apt. #, Etc. Suite A City State Zip Code ST Augustine FL 32086				☐ A \$100 reinstatement fee is imposed, except in circumstances which the entity did not receive the prior notices. By checking this box, you are certifying the prior notices were not received and requesting the \$100 reinstatement be waived.																	
9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S. Signature of Registered Agent _____ Date 6.19.07 REGISTERED AGENT MUST SIGN																					
10. Names and Street Addresses of Managing Members/Managers <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Titles</th> <th>Name of Managing Members/Managers</th> <th>Street Address of Each Managing Member/Manager</th> <th>City / State / Zip</th> </tr> </thead> <tbody> <tr> <td>P/MGR</td> <td>ALLAIN GIROUARD</td> <td>Same as above</td> <td></td> </tr> <tr> <td>T</td> <td>ALLAIN GIROUARD</td> <td>Same as above</td> <td></td> </tr> <tr> <td>S</td> <td>ALLAIN GIROUARD</td> <td>Same as above</td> <td></td> </tr> </tbody> </table>						Titles	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip	P/MGR	ALLAIN GIROUARD	Same as above		T	ALLAIN GIROUARD	Same as above		S	ALLAIN GIROUARD	Same as above	
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000105868240 07/10/07--01039--011 ***350.00 REINSTATEMENT 03-07 RA																					
11. I certify that I am managing member/manager or the receiver or trustee empowered to execute this application as provided for in chapter 608, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirements of section 608.408, F.S., and that all fees owed by the limited liability company have been paid. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. Signature of Managing Member/Manager _____ Date 6.19.07 Daytime Phone # 904-797 7463 Typed or printed name of signing Managing Member/Manager ALLAIN GIROUARD MD																					