2003 LIMITED LIABILITY COMPANY UNIFORM BUSINESS REPORT (UBR)

03-18-2003 90155 039 ****50.00
09-17-2003 90011 034 ****50.00
L02000007911

DOCUMENT # L02000007911

1. Entity Name

NAWADA AMBULATORY SURGICAL CENTER, LLC

FILED
03 OCT 21 AM 8:00
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business	Mailing Address
1121 1ST STREET, S WINTER HAVEN FL 33880	1121 1ST STREET, S WINTER HAVEN FL 33880

☐ CHECK HERE IF MAKING CHANGES

2. Principal Place of Business	3. Mailing Address
Same as above	Same as above
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. FEI Number NOT APPLICABLE ☐ 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
C.U. NAWADA 1121 1ST STREET, S WINTER HAVEN FL 33880	Name: NA 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: NA
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 Florida Department of State
Due By September 24, 2003

9. MANAGING MEMBERS / MANAGERS			10. ADDITIONS / CHANGES		
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	Managing Member C.U. Nawada 271 Lake Link Rd., S.E. Winter Haven, FL 33884	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	no change	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ 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 (4/03)

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 REQUIRED 9.15.03 863 293 2924
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #
C.U. NAWADA M.D.