FILED
Jun 05, 2003 8:00 am
Secretary of State
01-27-2003 90082 026 ****50.00

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2003 LIMITED LIABILITY COMPANY UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # L02000011564

1. Entity Name
ADVANCED BACK & NECK PAIN, PLLC

44003459

Principal Place of Business	Mailing Address
927 N. SPRING GARDEN AVENUE A DELAND FL 32720 US	927 N. SPRING GARDEN AVENUE A DELAND FL 32720 US
2. Principal Place of Business: 1025 N. STONE ST	3. Mailing Address: 1025 N. STONE
Suite, Apt. #, etc.: A	Suite, Apt. #, etc.: A
City & State: DELAND FL	City & State: DELAND FL
Zip: 32720 Country	Zip: 32720 Country

☐ CHECK HERE IF MAKING CHANGES

4. FEI Number: 27-0011985 — Applied For / Not Applicable

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

6. Name and Address of Current Registered Agent

REINLIE, KENNING J
1735 ALDEN STREET
DELAND FL 32720

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 ______ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS $50.00
Make Check Payable to Florida Department of State
Due By May 1, 2003

9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	Dr. Gary Schlapper 1025 A North Stone Deland, FL 32720 ☐ 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
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
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TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition

CR2E083 (10/02)

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: SIGNATURE REQUIRED 1-21-03 386-738-3774
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #

Attachment #

Advanced Neck and Back Pain Center

A State of the Art Facility with Advanced Diagnostic and Treatment Equipment

GARY L. SCHLAPPER, D.C.
Chiropractic Physician

44003459 June 3, 03

Florida Department of State.

Ref No K02000011564

Have sent check and have provided additional information as requested. You keep sending it back. What am I not doing. Please hi-lite, circle or star what has to be filled out.

Sincerely

1025-A North Stone Street • DeLand, Florida 32720
(386) 738-3774 • Fax (386) 738-2080