

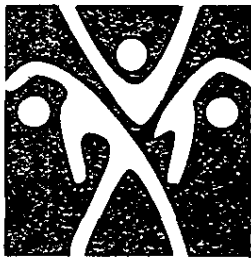
FILED
Jun 05, 2003 8:00 am
Secretary of State

01-27-2003 90082 026 ****50.00

2003 LIMITED LIABILITY COMPANY
UNIFORM BUSINESS REPORT (UBR)

1/2

DOCUMENT # L02000011564			
1. Entity Name ADVANCED BACK & NECK PAIN, PLLC			
Principal Place of Business 927 N. SPRING GARDEN AVENUE A DELAND FL 32720 US		Mailing Address 927 N. SPRING GARDEN AVENUE A DELAND FL 32720 US	
2. Principal Place of Business 1025 N. STONE ST A City & State DELAND FL Zip 32720		3. Mailing Address 1025 N. STONE A City & State DELAND FL Zip 32720	
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 <u>C</u> (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 May 1, 2003			
9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP Dr. Gary Schlagger 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
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: <u>SIGNATURE REQUIRED</u> (Signature, typed or printed name of signing managing member, manager, or authorized representative)		Date <u>1-21-03</u> 386-738-3774 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 202000011564

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

Sincerely,