


**2005 LIMITED LIABILITY COMPANY  
ANNUAL REPORT**

**FILED**  
**Apr 07, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # L02000016775</b> 1. Entity Name HAROLD J. COLBASSANI, M.D. NEUROSURGERY CONSULTANTS, P.L.	
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Principal Place of Business 646 VIRGINIA ST. SUITE 600 DUNEDIN, FL 34698 US	Mailing Address 646 VIRGINIA ST. SUITE 600 DUNEDIN, FL 34698 US
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**DO NOT WRITE IN THIS SPACE**



03042005No Chg-LLC

CR2E083 (10/03)

4. FEI Number 01-0729262	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$5.00 Additional Fee Required

6. Name and Address of Current Registered Agent  COLBASSANI, CHARLES 646 VIRGINIA ST. SUITE 600 DUNEDIN, FL 34698	<b>DO NOT WRITE IN THIS SPACE</b>
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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 \_\_\_\_\_

**Filing Fee is \$50.00  
Due by May 1, 2005**

9. MANAGING MEMBERS/MANAGERS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGR COLBASSANI, HAROLD J M.D. 646 VIRGINIA STREET, SUITE 600 DUNEDIN, FL 34698
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04/07/05-80008-011 50.00

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11. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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

3-28-05

Date

727.733.4151

Daytime Phone #