

**2008 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
Jan 24, 2008 08:00 AM
Secretary of State

DOCUMENT # L02000027895

1. Entity Name
BAYCARE ANESTHESIA ASSOCIATES, LLC



Principal Place of Business
7050 GALL BLVD
OR SUITE
ZEPHYRHILLS, FL 33541

Mailing Address
P.O. BOX 1204
OLDSMAR, FL 34677



01142008 No Chg-LLC

CR2E083 (12/07)

DO NOT WRITE IN THIS SPACE

4. FEI Number
01-0750405

Applied For
Not Applicable

5. Certificate of Status Desired ☐

\$5.00 Additional
Fee Required

6. Name and Address of Current Registered Agent

BELLINO, PAULA M
12016 WANDSWORTH DRIVE
TAMPA, FL 33626

**DO NOT WRITE
IN THIS SPACE**

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 file if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE _____

FILE NOW!!! FEE IS \$138.75
After May 1, 2008 Fee will be \$538.75

9. MANAGING MEMBERS/MANAGERS

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
MGRM
BELLINO, PAULA M
12016 WANDSWORTH DR.
TAMPA, FL 33626

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CITY-ST-ZIP

000000795000
01/29/08-80014-018 138.75

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IN THIS SPACE**

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: _____

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE

Paula Bellino

Date

1/18/08

Daytime Phone #

83-
263-2911