


2007 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Mar 06, 2007 8:00 am
Secretary of State

03-06-2007 90076 017 ****50.00

DOCUMENT # L02000030885 1. Entity Name KINGS HIGHWAY MEDICAL GROUP, L.C.					
Principal Place of Business P.O. BOX 510065 PUNTA GORDA, FL 33951			Mailing Address P.O. BOX 510065 PUNTA GORDA, FL 33951		
2. Principal Place of Business - No P.O. Box # Suite, Apt. #, etc.			3. Mailing Address Suite, Apt. #, etc.		
City & State			City & State		
Zip		Country		Zip	
Country		Country		4. FEI Number 71-0910174	
5. Certificate of Status Desired <input type="checkbox"/>				Applied For Not Applicable	
6. Name and Address of Current Registered Agent KAHLE, GARY A ESQ. 99 NESBIT STREET PUNTA GORDA, FL 33950				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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____					
Filing Fee is \$50.00 Due by May 1, 2007			Make check payable to Florida Department of State		
9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR HERNANDEZ, MANUEL M.D. 3582 TRIPOLY BLVD PUNTA GORDA, FL 33950	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition 12740 Terabella Way Ft. Myers, FL 33912
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR MAAS, MARIA CELINA TRUSTEE 1775 CITRON ST. CHARLOTTE HARBOR, FL 33980	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR MENA, ROSA M.D. 275 FRY TERRACE SE PORT CHARLOTTE, FL 33952	<input checked="" type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR GIL, RAMON A M.D. 197 ROSELLE CT. PORT CHARLOTTE, FL 33952	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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 <i>Manuel Hernandez</i> Manuel Hernandez, MD			Date 1-19-07		Daytime Phone # 941.764.7773