


**2003 LIMITED LIABILITY COMPANY
UNIFORM BUSINESS REPORT (UBR)**

FILED
May 02, 2003 8:00 am
Secretary of State

05-02-2003 90577 040 ****50.00

DOCUMENT # L02000035196

1. Entity Name
REGIONAL OSTEOPOROSIS CENTER OF STUART, LLC



Principal Place of Business
2081 EAST OCEAN BLVD., STE 1A
STUART, FL 34996

Mailing Address
2081 EAST OCEAN BLVD., STE 1A
STUART, FL 34996

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

City & State

Zip Country



CHECK HERE IF MAKING CHANGES

4. FEI Number
27-0039914

Applied For
 Not Applicable

5. Certificate of Status Desired **\$5.00 Additional Fee Required**

6. Name and Address of Current Registered Agent

FISKE, DARRELL N M.D.
2081 EAST OCEAN BLVD., SUITE 1A
STUART, FL 34996

7. Name and Address of New Registered Agent

Name

Street Address (P.O. Box Number is Not Acceptable)

City **FL** Zip Code

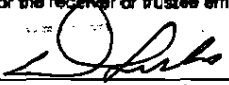
8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE _____ DATE _____

(Signature, typed or printed name of registered agent and date if applicable. (NOTE: Registered Agent signature required when re-registering.)

9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM FISKE, DARRELL N M.D. 2081 EAST OCEAN BLVD., SUITE 1A STUART, FL 34996 <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	MGRM HOURI, JOHN M M.D. 2081 EAST OCEAN BLVD., SUITE 1A STUART, FL 34996 <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	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	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	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 exemption stated in Section 119.07(3)(b), 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:  **Darrell N. Fiske, M.D.** **04-22-03** **772-286-9779**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #