


**2004 LIMITED LIABILITY COMPANY ANNUAL REPORT (AR)**

**FILED**  
**Jun 07, 2004 8:00 am**  
**Secretary of State**

04-29-2004 90083 004 \*\*\*\*50.00

4/29/04  
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**DOCUMENT # L03000014433**  
 1. Entity Name  
**PAIN MEDICINE SOLUTIONS, LLC**



Principal Place of Business Mailing Address  
**8603 SOUTH DIXIE HIGHWAY SUITE 401 MIAMI FL 33143**

2. Principal Place of Business 3. Mailing Address  
 Suite, Apt. #, etc. Suite, Apt. #, etc.

City & State City & State  
 Zip Country Zip Country

**34008269**  
  
**MOORE CR2E083 (11/03)**  
 4. FEI Number **04-3766998** Applying For  Not Applicable  
 5. Certificate of Status Desired  \$5.00 Additional Fee Required

6. Name and Address of Current Registered Agent  
**AMERICAN INFORMATION SERVICES, INC.**  
**ONE S.E. THIRD AVE., 28TH FLOOR**  
**MIAMI FL 33131**

7. Name and Address of New Registered Agent  
 Name **ALBERT RAY, M.D.**  
 Street Address (P.O. Box Number is Not Acceptable) **6003 S. DIXIE HIGHWAY # 401**  
**MIAMI, FL**  
 City **MIAMI** FL Zip Code **33143**

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 **4/27/04**

**FILE NOW!!! FEE IS \$50.00**  
 Make Check Payable to Florida Department of State  
 Due By May 1, 2004

9. MANAGING MEMBERS/MANAGERS

|                                       |  |                                 |
|---------------------------------------|--|---------------------------------|
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <b>PARTNER ALBERT RAY, MD 8603 S. DIXIE HWY # 401 MIAMI, FL 33143</b>      | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <b>PARTNER ALBERT ZBIK, PSY.D. 8603 S. DIXIE HWY # 401 MIAMI, FL 33143</b> | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP |  | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP |  | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP |  | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP |  | <input type="checkbox"/> Delete |

10. ADDITIONS/CHANGES

|                                       |                 |  |
|---------------------------------------|-----------------|--|
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <b>DIRECTOR</b> | <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <b>DIRECTOR</b> | <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition |
| 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"/> Change <input type="checkbox"/> Addition            |
| 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"/> 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)(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:  DATE **2/27/04** 205-5954481  
SIGNATURE AND TYPED OR PRINTED NAME OF EACH MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE DAYTIME PHONE #