2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Aug 15, 2008 8:00 am
Secretary of State
08-15-2008 90025 017 ***538.75

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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	8603 SOUTH DIXIE HIGHWAY SUITE 401 MIAMI, FL 33143

2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

07212008 Chg-LLC CR2E083 (12/06)

4. FEI Number: 04-3766998 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
CORPDIRECT AGENTS, INC. 515 EAST PARK AVENUE TALLAHASSEE, FL 32301	Name: ALBERT L. RAY, M.D. Street Address (P.O. Box Number is Not Acceptable): 8603 S. DIXIE HWY SUITE 401 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 [signature] ALBERT L. RAY, M.D. 8/12/08
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $538.75
Due by September 12, 2008

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE	MGR	☐ Delete	TITLE		☐ Change ☐ Addition
NAME	RAY, ALBERT MD		NAME		
STREET ADDRESS	8603 S DIXIE HWY., #401		STREET ADDRESS		
CITY-ST-ZIP	MIAMI, FL 33143		CITY-ST-ZIP		
TITLE	MGR	☒ Delete	TITLE		☐ Change ☐ Addition
NAME	ZBIK, ALBERT PSYD		NAME		
STREET ADDRESS	8603 S DIXIE HWY., #401		STREET ADDRESS		
CITY-ST-ZIP	MIAMI, FL 33143		CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
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TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
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CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		

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] ALBERT L. RAY, M.D. 8/12/08 305-595-4681
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #