


**2008 LIMITED LIABILITY COMPANY ANNUAL REPORT**

**FILED**  
**Aug 15, 2008 8:00 am**  
**Secretary of State**

08-15-2008 90025 017 \*\*\*538.75

**DOCUMENT # L03000014433**  
 1. Entity Name  
**PAIN MEDICINE SOLUTIONS, LLC**



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

**50009512**



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      Applied For  
**04-3766998**      Not Applicable

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

6. Name and Address of Current Registered Agent

**CORPDIRECT AGENTS, INC.**  
**515 EAST PARK AVENUE**  
**TALLAHASSEE, FL 32301**

7. Name and Address of New Registered Agent

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      **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

TITLE      MGR       Delete  
 NAME      **RAY, ALBERT MD**  
 STREET ADDRESS      **8603 S DIXIE HWY., #401**  
 CITY-ST-ZIP      **MIAMI, FL 33143**

TITLE      MGR       Delete  
 NAME      **ZBIK, ALBERT PSYD**  
 STREET ADDRESS      **8603 S DIXIE HWY., #401**  
 CITY-ST-ZIP      **MIAMI, FL 33143**

TITLE      \_\_\_\_\_       Delete  
 NAME      \_\_\_\_\_  
 STREET ADDRESS      \_\_\_\_\_  
 CITY-ST-ZIP      \_\_\_\_\_

TITLE      \_\_\_\_\_       Delete  
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 NAME      \_\_\_\_\_  
 STREET ADDRESS      \_\_\_\_\_  
 CITY-ST-ZIP      \_\_\_\_\_

10. ADDITIONS/CHANGES

TITLE      \_\_\_\_\_       Change       Addition  
 NAME      \_\_\_\_\_  
 STREET ADDRESS      \_\_\_\_\_  
 CITY-ST-ZIP      \_\_\_\_\_

TITLE      \_\_\_\_\_       Change       Addition  
 NAME      \_\_\_\_\_  
 STREET ADDRESS      \_\_\_\_\_  
 CITY-ST-ZIP      \_\_\_\_\_

TITLE      \_\_\_\_\_       Change       Addition  
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 STREET ADDRESS      \_\_\_\_\_  
 CITY-ST-ZIP      \_\_\_\_\_

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TITLE      \_\_\_\_\_       Change       Addition  
 NAME      \_\_\_\_\_  
 STREET ADDRESS      \_\_\_\_\_  
 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:      **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 #