

**2007 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
Feb 19, 2007 08:00 AM
Secretary of State

DOCUMENT # L03000026875

1. Entity Name
JAY MEDICAL PHYSICIANS, L.L.C.



Principal Place of Business

**14088 ALBAMA ST
JAY, FL 32565**

Mailing Address

**P.O. BOX 10
JAY, FL 32565**



02062007 No Chg-LLC

CR2E083 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
14-1893324

Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

**SMITH, C. DAVID M.D.
5100 HIGHWAY 4
JAY, FL 32565**

**DO NOT WRITE
IN THIS SPACE**

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, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE _____

**Filing Fee is \$50.00
Due by May 1, 2007**

9. MANAGING MEMBERS/MANAGERS

TITLE	MGRM
NAME	SMITH, C. DAVID M.D.
STREET ADDRESS	5100 HIGHWAY 4
CITY-ST-ZIP	JAY, FL 32565
TITLE	MGRM
NAME	SMITH, JOHN-STEWART M M.D.
STREET ADDRESS	5100 HIGHWAY 4
CITY-ST-ZIP	JAY, FL 32565
TITLE	MGRM
NAME	STEWART, MARIAN B M.D.
STREET ADDRESS	13060 CHUMUCKLA HIGHWAY
CITY-ST-ZIP	JAY, FL 32565
TITLE	MGRM
NAME	KELLEY, JEFFERY S M.D.
STREET ADDRESS	P.O. BOX 1
CITY-ST-ZIP	JAY, FL 32565
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

U00000639195
02/28/07-80015-023 50.00

**DO NOT WRITE
IN THIS SPACE**

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: _____

C. David Smith M.D.

2/16/07

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #