

2005 LIMITED LIABILITY COMPANY ANNUAL REPORT (AR)

FILED
Jun 06, 2005 8:00 am
Secretary of State

04-29-2005 90052 036 ****50.00

DOCUMENT # L03000030576

1. Entry Name
THE MOBILE ANIMAL HOSPITAL, P.L.



Principal Place of Business
**1787 LAKEWOOD RANCH BLVD
#228
BRADENTON FL 34211**

Mailing Address
**1787 LAKEWOOD RANCH BLVD
#228
BRADENTON FL 34211**

2. Principal Place of Business
Suite, Apt. #, etc.

3. Mailing Address
Suite, Apt. #, etc.

City & State

Zip Country

01-017498008769



1st MOORE CR2E083 (10/04)

4. FEE Number **AP-PLIED FOR**
01-794980

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

6. Name and Address of Current Registered Agent
**WICKMAN & WYCKOFF, P.A.
4909 MANATEE AVENUE WEST
BRADENTON FL 34209**

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 _____ (NOTE: Registered Agent signature required when re-issuing) DATE _____

FILE NOW!!! FEE IS \$50.00
Make Check Payable to Florida Department of State
Due By May 1, 2005

9. MANAGING MEMBERS / MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGR SPIEZIO, DR. JAMES P 12724 ROCKROSE GLEN BRADENTON FL 34202 <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
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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)(f), 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: James P. Spizio, Manager 4/25/05 (941) 526-2016
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

ATTACHMENT # 30007169 000030576

Form **SS-4**

(Rev. December 2001)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ See separate instructions for each line. ▶ Keep a copy for your records.

EIN **01-0794886**

OMB No. 1545-0003

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested The Mobile Animal Hospital, PL			
2 Trade name of business (if different from name on line 1)		3 Executor, trustee, "care of" name	
4a Mailing address (room, apt., suite no. and street, or P.O. box) 1767 Lakewood Ranch Blvd. #228		5a Street address (if different) (Do not enter a P.O. box.)	
4b City, state, and ZIP code Bradenton, FL 34211		5b City, state, and ZIP code	
6 County and state where principal business is located Manatee county, Florida			
7a Name of principal officer, general partner, grantor, owner, or trustor James P. Spiezio, Manager		7b SSN, ITIN, or EIN 114-54-3905	
8a Type of entity (check only one box) <input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____ <input type="checkbox"/> Personal service corp. <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input checked="" type="checkbox"/> Other (specify) ▶ Single Member LLC-Disregarded entity <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Plan administrator (SSN) _____ <input type="checkbox"/> Trust (SSN of grantor) _____ <input type="checkbox"/> National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises Group Exemption Number (GEN) ▶ _____			
8b If a corporation, name the state or foreign country (if applicable) where incorporated State Florida		Foreign country	
9 Reason for applying (check only one box) <input checked="" type="checkbox"/> Started new business (specify type) ▶ Veterinarian services <input type="checkbox"/> Hired employees (Check the box and see line 12.) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) ▶ _____ <input type="checkbox"/> Banking purpose (specify purpose) ▶ _____ <input type="checkbox"/> Changed type of organization (specify new type) ▶ _____ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> Created a pension plan (specify type) ▶ _____			
10 Date business started or acquired (month, day, year) 08/15/03		11 Closing month of accounting year December	
12 First date wages or annuities were paid or will be paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year) ▶			
13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter "-0-." ▶		Agricultural	Household
		0	0
14 Check one box that best describes the principal activity of your business. <input checked="" type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Other (specify) _____			
15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. provide veterinary services			
16a Has the applicant ever applied for an employer identification number for this or any other business? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Note: If "Yes," please complete lines 16b and 16c.			
16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above. Legal name ▶ _____ Trade name ▶ _____			
16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (mo., day, year) _____ City and state where filed _____ Previous EIN _____			
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.		
	Designee's name _____		Designee's telephone number (include area code) _____
	Address and ZIP code _____		Designee's fax number (include area code) _____
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.			
Name and title (type or print clearly) ▶ James P. Spiezio, DVM, Manager			Applicant's telephone number (include area code) _____ (941) 526-8046
Signature ▶ _____ Date ▶ _____			Applicant's fax number (include area code) _____ ()