


**2005 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
Apr 25, 2005 08:00 AM
Secretary of State

DOCUMENT # L03000040358 1. Entity Name OUTPATIENT ANESTHESIA SERVICES, LLC	
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Principal Place of Business 1325 S. CONGRESS AVE., STE. 211 BOYNTON BEACH, FL 33426	Mailing Address 1325 S. CONGRESS AVE., STE. 211 BOYNTON BEACH, FL 33426
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DO NOT WRITE IN THIS SPACE



04212005 No Chg-LLC

CR2E083 (10/03)

4. FEI Number 55-0852092	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$5.00 Additional Fee Required

6. Name and Address of Current Registered Agent

**MENKHAUS, DAVID J
2424 N. FEDERAL HWY., STE. 456
BOCA RATON, FL 33431**

**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: _____ (NOTE: Registered Agent signature required when filing statement)

SIGNATURE, typed or printed name of registered agent and title if applicable. DATE: **4/25/05**

**Filing Fee is \$50.00
Due by May 1, 2005**

9. MANAGING MEMBERS/MANAGERS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM DOSCH, MARK R 4615 PINE TREE DRIVE BOYNTON BEACH, FL 33436
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR DEGEROME, JAMES H 1422 SE ATLANTIC DR LANTANA, FL 33426
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	

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IN THIS SPACE**

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

DATE: _____ DAYTIME PHONE #: _____