

**2007 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED
May 02, 2007 8:00 am
Secretary of State

05-02-2007 90344 035 ****50.00

DOCUMENT # L03000045086

1. Entity Name
ALL CARE PAIN MANAGEMENT CENTER, LLC



Principal Place of Business
6513 14TH ST WEST
SUITE 117
BRADENTON, FL 34207

Mailing Address
2205 HICKORY RIDGE DRIVE
VALRICO, FL 33594



04292007 No Chg-LLC

CR2E083 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
35-2220197

Applied For
Not Applicable

5. Certificate of Status Desired ☐

\$5.00 Additional
Fee Required

6. Name and Address of Current Registered Agent

NEIL S. SCHECHT, PA
3630 W. KENNEDY BLVD.
TAMPA, FL 33609

**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

Stephen J. Skolnick
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
NAME
STREET ADDRESS
CITY - ST - ZIP
MGRM
SKOLNICK, STEPHEN J
2205 HICKORY RIDGE DRIVE
VALRICO, FL 33594

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

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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 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:

Stephen J. Skolnick
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

4/30/2007

813-928-1876