


2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Jun 29, 2005 8:00 am
Secretary of State


04-28-2005 90049 001 *3,150.00

DOCUMENT # L04000020840	
1. Entity Name ROBERT A. ROSS MD, LLC	

Principal Place of Business 3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741	Mailing Address 3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741
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2. Principal Place of Business 9150 SW 87 AVE	3. Mailing Address
Suite, Apt. #, etc. Ste. 212	Suite, Apt. #, etc.
City & State Miami, FL	City & State
Zip 33170	Country U.S.A.

30003022 - 1



04202005 Chg-LLC CR2E083 (10/03)

4. FEI Number 54-2129332	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 YELEN, MITCHELL A 3225 AVIATION AVE., SUITE 500 MIAMI, FL 33133-4741	
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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 reinstating) DATE _____

Filing Fee is \$50.00 Due by May 1, 2005	Make check payable to Florida Department of State
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9. MANAGING MEMBERS/MANAGERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input checked="" 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)(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: Mitchell A. Yelen **04/25/05 305-858-5800**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

MITCHELL A YELEN

**STATE OF FLORIDA
OFFICE OF THE COMPTROLLER
APPLICATION FOR REFUND**

ATTACHMENT 30009822
#604000020840

Section 215.26, Florida Statutes, states in part: "Applications for refunds as provided in this section shall be filed with the Comptroller, except as otherwise provided herein, within 3 years after the right to such refund shall have accrued else such right shall be barred." Three years is generally interpreted as meaning three years from the date of payment into the State Treasury. The Comptroller has delegated the authority to accept applications for refund to the unit of State government which initially collected the money.

Pursuant to the provisions of Rule 3A-44.020, Florida Administrative Code, and Section 215.26, Florida Statutes, or Section _____, Florida Statutes, I hereby apply for a refund of moneys I paid into the State Treasury, which are subject to refund. The following information is submitted to substantiate the claim.

THE INFORMATION IN THIS BOX WILL BE USED TO WRITE AND MAIL YOUR REFUND CHECK. PLEASE TYPE OR PRINT LEGIBLY.

Name: _____ EIN or SS#: _____

Address: _____

Amount: _____ Date Paid: _____

Reason for Claim: _____

Certified true and correct this _____ day of _____, _____.

Signature _____

* Must be completed if authority is other than Section 215.26, Florida Statutes.

Do Not Write in This Box - For Agency Use Only

Amount of recommended refund \$ 50.00

The amount requested above was originally deposited into the State Treasury, as a part of the funds deposited on

State Treasurer's Receipt No. 900497-001 *dated* 4/28/05

NAME OF ACCOUNT: 45101000132453001000001000000

Statutory Authority for Collection 608.0452

It is requested that payment be made from the following account:

NAME OF ACCOUNT: 45101000132453001000022002000

Certified true and correct this _____ day of _____, _____.

Department of State, Division of Corporations

(Agency)

(Authorized Agency Signature and Title)

5/31/05 CORPORATE DETAIL RECORD SCREEN
NUM: L04000020840 ST:FL ACTIVE/FL LIM LIAB FLD: 03/11/2004
TOTAL CONTR: 0.00

1:59 PM

NAME : ROBERT A. ROSS MD, LLC
PRINCIPAL: 3225 AVIATION AVE., SUITE 500
ADDRESS MIAMI, FL 33133-4741
RA NAME : YELEN, MITCHELL A
RA ADDR : 3225 AVIATION AVE., SUITE 500
MIAMI, FL 33133-4741
ANN REP : * NONE FILED *

ATTACHMENT
#

3009822

1. MENU

ENTER SELECTION AND CR: