

# 2005 LIMITED LIABILITY COMPANY ANNUAL REPORT (AK)

**FILED**  
**Apr 04, 2005 8:00 am**  
**Secretary of State**

02-11-2005 90139 038 \*\*\*\*50.00

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1st MOORE CR2E083 (10/04)

<b>DOCUMENT # L04000076002</b> 1. Entity Name <b>MIAMI-DADE MEDICAL SERVICES, LLC</b>					
Principal Place of Business <b>505 WEST 47TH STREET MIAMI BEACH FL 33140</b>			Mailing Address <b>505 WEST 47TH STREET MIAMI BEACH FL 33140</b>		
2. Principal Place of Business Suite, Apt. #, etc.			3. Mailing Address Suite, Apt. #, etc.		
City & State			City & State		
Zip		Country		4. FEI Number <b>20-1788808</b>	
5. Certificate of Status Desired <input type="checkbox"/> \$5.00 Additional Fee Required				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent <b>POMPER, MARK E M.D. 505 WEST 47TH STREET MIAMI BEACH FL 33140</b>				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <b>FL</b> 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 _____					
<b>FILE NOW!!! FEE IS \$50.00</b> <b>Make Check Payable to Florida Department of State</b> <b>Due By May 1, 2005</b>					
<b>9. MANAGING MEMBERS / MANAGERS</b>			<b>10. ADDITIONS / CHANGES</b>		
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM POMPER, MARK E M.D. 505 WEST 47TH STREET MIAMI BEACH FL 33140	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM DIAZ-RANGEL, LUIS G M.D. 777 EAST 25TH STREET, SUITE 411 HIALEAH FL 33013	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM VAZQUEZ, GUILLERMO M.D. 7000 S.W. 97TH AVE., SUITE 207 MIAMI FL 33173	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY - ST - ZIP	MGRM HAMADY, GHASSAN T M.D. 7150 WEST 20TH AVE., SUITE 406 HIALEAH FL 33016	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete				
TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete				
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.					
<b>SIGNATURE:</b> <u>Mark E. Pomper, M.D. (MARK E. Pomper, M.D.)</u> <b>2/1/05</b> <b>705-534-2122</b> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE</small>					