


2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Apr 18, 2008 8:00 am
Secretary of State

04-18-2008 90151 034 ***138.75

DOCUMENT # L05000092722 1. Entity Name CENTRAL FLORIDA ENDOSCOPY & SURGICAL INSTITUTE OF OCALA, LLC					
Principal Place of Business 316 SE 12TH STREET #200 OCALA, FL 34471			Mailing Address 11231 CAMDEN PARK DRIVE WINDERMERE, FL 34786		
2. Principal Place of Business - No P.O. Box # Suite, Apt. #, etc.		3. Mailing Address 11253 Bridgehouse Rd. Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country		
4. FEI Number 20-3520333				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 REDDY, VISHNU DR. 11231 CAMDEN PARK DRIVE WINDERMERE, FL 34786			7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) 11253 Bridgehouse Rd. 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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>					
FILE NOW!!! FEE IS \$138.75 After May 1, 2008 Fee will be \$538.75		Make check payable to Florida Department of State			
9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PD REDDY, VISHNU P MD 11231 CAMDEN PARK DRIVE WINDERMERE, FL 34786 <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY - ST - ZIP	11253 Bridgehouse Rd. <input checked="" 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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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: _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE</small>			4.15.08 352.488.7895 <small>Date Daytime Phone #</small>		