## **2006 LIMITED LIABILITY COMPANY**

## May 01, 2006 8:00 am Secretary of State **ANNUAL REPORT** DOCUMENT #L05000113399 05-01-2006 90063 043 \*\*\*\*50.00 TRINITY PAIN MANAGEMENT, PL Principal Place of Business Mailing Address 6600 MADISON STREET 6600 MADISON STREET NEW PORT RICHEY, FL 34652 **NEW PORT RICHEY, FL 34652** 2. Principal Place of Business 3. Mailing Address 1814 Wellness 814 Wellness Lane Suite, Apt. #, etc. Suite, Apt. #, etc. 04192006 Chg-LLC CR2E083 (11/05) City & State City & State 4. FEI Number Applied For New Port Richey New Port 20-391227 Not Applicable Zip \$5.00 Additional 5. Certificate of Status Desired 34655 Fee Required 7. Name and Address of New Registered Agent 6. Name and Address of Current Registered Agent Name MARQUARDT, EMIL C JR Street Address (P.O. Box Number is Not Acceptable) 625 COURT STREET STE 200 CLEARWATER, FL 33756 City 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, typed or printed pame of registered agent and title if applicable. (NQTE: Registered Agent signature required when reinstating) DATE Filing Fee is \$50.00 Due by May 1, 2006 Make check payable to Florida Department of State MANAGING MEMBERS/MANAGERS 9. ADDITIONS/CHANGES 10. TITLE MGRM Delete . TITLE MGRM **万**€.Change ☐ Addition SAID, NADER M.D. SAID NADER NAME NAME STREET ADDRESS 6600 MADISON STREET STREET ADDRESS 1814 Wellness Lane CITY-ST-ZIP NEW PORT RICHEY, FL 34652 CITY-ST-ZIP New Port Richey FL 34652 MGRM TITLE Delete ☐ Change ☐ Addition DAHLAWAL, TEJINDER M.D. NAME NAME STREET ADDRESS 6600 MADISON STREET STREET ADDRESS CITY-ST-ZIP NEW PORT RICHEY, FL 34652 CITY-ST-ZIP TITLE □ Delete TITLE ☐ Change ☐ Addition NAME NAME STREET ADDRESS STREET ADDRESS CITY-ST-ZIP CITY-ST-ZIP TITLE Delete TITLE ☐ Change Addition NAME NAME STREET ADDRESS STREET ADDRESS CITY-ST-ZIP CITY-ST-7IP TITLE ☐ Delete TITLE ☐ Change ☐ Addition NAME NAME STREET ADDRESS STREET ADDRESS CITY-ST-ZIP CITY-ST-ZIP ☐ Delete TITLE TITLE ☐ Change Addition NAME NAME STREET ADDRESS STREET ADDRESS CITY-ST-ZIP CITY-ST-ZIP

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 cath; 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, MANAGER, OR AUTHORIZED REPRESENTATIVE

412516

Daytime Phone #

FILED