2007 LIMITED LIABILITY COMPANY ANNUAL REPORT

9/6/2007-90037-041-$50.00-$50.00

FILED 07 SEP 26 PM 2:43 SECRETARY OF STATE DIVISION OF CORPORATIONS

DOCUMENT # L06000000084

1. Entity Name
DOCTORS CLINIC FAMILY HEALTH CENTER LLC

Principal Place of Business	Mailing Address
204 ES PARK STREET OKEECHOBEE, FL 34972 US	204 ES PARK STREET OKEECHOBEE, FL 34972 US
2. Principal Place of Business - No P.O. Box #	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

07162007 Chg-LLC CR2E083 (12/06)

4. FEI Number 20-4021023 — Applied For / Not Applicable

5. Certificate of Status Desired ☐ $5.00 Additional Fee Required

6. Name and Address of Current Registered Agent

SWEDA, RENNAE
204 ES PARK STREET
OKEECHOBEE, FL 34972

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 ______ 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 September 14, 2007

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE	MGRM	☐ Delete	TITLE		☐ Change ☐ Addition
NAME	SWEDA, STANLEY DR		NAME		
STREET ADDRESS	204 ES PARK STREET		STREET ADDRESS		
CITY-ST-ZIP	OKEECHOBEE, FL 34972		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-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-ZIP		
TITLE		☐ Delete	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 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: Stanley Sweda 8/21/07 863-697-3069
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #