

# **2007 LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L06000015475

**FILED**  
**Feb 15, 2007**  
**Secretary of State**

**Entity Name:** NATIONWIDE AMBULATORY ANESTHESIA SPECIALISTS, LLC

**Current Principal Place of Business:**

1635 SHELLPOINT ROAD  
CRAWFORDVILLE, FL 32327

**New Principal Place of Business:**

**Current Mailing Address:**

1635 SHELLPOINT ROAD  
CRAWFORDVILLE, FL 32327

**New Mailing Address:**

**FEI Number:** **FEI Number Applied For ( )** **FEI Number Not Applicable (X)** **Certificate of Status Desired ( )**

**Name and Address of Current Registered Agent:**

JOHNS, TOM  
1635 SHELLPOINT ROAD  
CRAWFORDVILLE, FL 32327 US

**Name and Address of New Registered Agent:**

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.

SIGNATURE: \_\_\_\_\_

Electronic Signature of Registered Agent

\_\_\_\_\_ Date

**MANAGING MEMBERS/MANAGERS:**

Title: ( ) Delete  
Name:  
Address:  
City-St-Zip:

**ADDITIONS/CHANGES:**

Title: CEO ( ) Change (X) Addition  
Name: JOHNS, TOM MR  
Address: 1635 SHELLPOINT ROAD  
City-St-Zip: CRAWFORDVILLE, FL 323274612 US

I hereby certify that the information supplied with this filing does not qualify for the for the exemption stated in Chapter 119, Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my electronic 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: TOM JOHNS

CEO

02/15/2007

\_\_\_\_\_  
Electronic Signature of Signing Managing Member, Manager, or Authorized Representative / Date