

2005 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Apr 12, 2005 08:00 AM
Secretary of State

DOCUMENT # L98000003414 1. Entity Name NEUROSCIENCE AND SPINE ASSOCIATES, P.L.					
Principal Place of Business 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110			Mailing Address 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110		
2. Principal Place of Business Suite, Apt #, etc			3. Mailing Address Suite, Apt. #, etc		
City & State			City & State		
Zip		Country		Zip	
Country		Country		4. FEI Number 65-0703990	
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 HUSSEY, F. DESMOND III 670 GOODLETTE ROAD NORTH NAPLES, FL 34102			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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>					
Filing Fee is \$50.00 Due by May 1, 2005		Make check payable to Florida Department of State			
9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM LUSK, MICHAEL D M.D. 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM SUDDERTH, DAVID B M.D. 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM NOVAK, MICHAEL D 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM KANDEL, JOSEPH MD 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM HUSSEY, F. DESMOND III MD 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM MORELL, THOMAS C M.D. 1660 MEDICAL BLVD., SUITE 200 NAPLES, FL 34110	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
11. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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>					
Date				Daytime Phone #	