

**2007 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

DOCUMENT # L99000002255

1. Entity Name
JACKSONVILLE PSYCHIATRIC SERVICES, P.L.



Principal Place of Business

**3599 UNIVERSITY BLVD
400
JACKSONVILLE, FL 32216**

Mailing Address

**3599 UNIVERSITY BLVD
400
JACKSONVILLE, FL 32216**

DO NOT WRITE IN THIS SPACE



01222007 No Chg-LLC

CR2E083 (11/05)

4. FEI Number

59-3573713

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$5.00 Additional
Fee Required

6. Name and Address of Current Registered Agent

**CHESHIRE, DAVID W.M.D.
3599 UNIVERSITY BLVD
400
JACKSONVILLE, FL 32216**

**DO NOT WRITE
IN THIS SPACE**

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 May 1, 2007**

9. MANAGING MEMBERS/MANAGERS

TITLE	MGRM
NAME	CHESHIRE, DAVID W.M.D.
STREET ADDRESS	3599 UNIVERSITY BLVD, STE 400
CITY-ST-ZIP	JACKSONVILLE, FL 32216

TITLE	
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01/31/07-80019-003 50.00

**DO NOT WRITE
IN THIS SPACE**

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: _____

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #