


2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 25, 2007 8:00 am
Secretary of State

01-25-2007 90056 026 ***150.00

DOCUMENT # P06000071892	
1. Entity Name TOTAL ANESTHESIA CARE INC	

Principal Place of Business 6053 SABAL CREEK BLVD PORT ORANGE, FL 32128	Mailing Address 6053 SABAL CREEK BLVD PORT ORANGE, FL 32128
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40005751



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

01062007 Chg-P CR2E034 (12/06)

4. FEI Number 20-4913123	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent		7. Name and Address of New Registered Agent	
LOGUIDICE, JOE 1515 RIDGEWOOD AVE., STE. A HOLLY HILL, FL 32117		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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00 After May 1, 2007 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	CONNOR, LEVINA	NAME	
STREET ADDRESS	6053 SABAL CREEK BLVD	STREET ADDRESS	
CITY-ST-ZIP	PORT ORANGE, FL 32128	CITY-ST-ZIP	
TITLE	P <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	MOYER, TERRY	NAME	
STREET ADDRESS	6053 SABAL CREEK BLVD	STREET ADDRESS	
CITY-ST-ZIP	PORT ORANGE, FL 32128	CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	

12. 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 or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: Levina Connor **Levina Connor** **Director** **1-22-07** **386-299-7397**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #