

**2016 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L01000006940

**Entity Name:** COASTAL INTERNAL MEDICINE SPECIALISTS, L.L.C.

**Current Principal Place of Business:**

335 CLYDE MORRIS BLVD.  
SUITE 290  
ORMOND BEACH, FL 32174

**Current Mailing Address:**

335 CLYDE MORRIS BLVD.  
SUITE 290  
ORMOND BEACH, FL 32174

**FEI Number:** 59-3757787

**Certificate of Status Desired:** No

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

TOWNSEND, MICHAEL  
335 CLYDE MORRIS BLVD  
SUITE 290  
ORMOND BEACH, FL 32174 US

*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

**Authorized Person(s) Detail :**

Title P  
Name TOWNSEND, MICHAEL EM.D.  
Address 335 CLYDE MORRIS, SUITE 290  
City-State-Zip: ORMOND BEACH FL 32174

Title T  
Name LASTARZA, MARK WM.D.  
Address 335 CLYDE MORRIS BLVD, SUITE 290  
City-State-Zip: ORMOND BEACH FL 32174

*I hereby certify that the information indicated on this report or supplemental 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 605, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.*

**SIGNATURE:** MICHAEL E TOWNSEND

**PRESIDENT**

**03/28/2016**

\_\_\_\_\_  
Electronic Signature of Signing Authorized Person(s) Detail

\_\_\_\_\_  
Date