

**2025 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L18000156155

**Entity Name:** POINT OF CARE HEALTH NET, LLC

**Current Principal Place of Business:**

2991 MAJESTIC ISLE DRIVE  
CLERMONT, FL 34711

**Current Mailing Address:**

P.O. BOX 121457  
CLERMONT, FL 34712

**FEI Number: 83-1088784**

**Certificate of Status Desired:** No

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

MITRE ACCOUNTING & TAX SERVICES, LLC.  
1635 E HIGHWAY 50, STE 206  
CLERMONT, FL 34711 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 MGR  
Name BECKFORD, ARLENE  
Address 2991 MAJESTIC ISLE DRIVE  
City-State-Zip: CLERMONT FL 34711

Title MGR  
Name BECKFORD, GEORGE  
Address 2991 MAJESTIC ISLE DRIVE  
City-State-Zip: CLERMONT FL 34711

Title MGR  
Name SKINNER, RETTA  
Address 4565 POWDERHORN PLACE DRIVE  
City-State-Zip: CLERMONT FL 34711

*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: GEORGE BECKFORD**

**MANAGING MEMBER**

**04/24/2025**

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

\_\_\_\_\_  
Date