

**2021 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L19000101908

**Entity Name:** SANFORD MEDICAL ALLIANCE LLC**Current Principal Place of Business:**610 LAKE MINNIE DR.  
SANFORD, FL 32773**Current Mailing Address:**2729 STATE ROAD 580  
CLEARWATER, FL 33761 US**FEI Number:** 83-4553859**Certificate of Status Desired:** Yes**Name and Address of Current Registered Agent:**MAZE, ILIANA  
2729 STATE ROAD 580  
CLEARWATER, FL 33761 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           | AMBR                | Title           | AUTHORIZED REPRESENTATIVE |
| Name            | MEDICAL UNITED LLC  | Name            | MAZE, ILIANA              |
| Address         | 2729 STATE ROAD 580 | Address         | 2729 STATE ROAD 580       |
| City-State-Zip: | CLEARWATER FL 33761 | City-State-Zip: | CLEARWATER FL 33761       |

|                 |                           |
|-----------------|---------------------------|
| Title           | AUTHORIZED REPRESENTATIVE |
| Name            | FIELD, IVAN               |
| Address         | 2729 STATE ROAD 580       |
| City-State-Zip: | CLEARWATER FL 33761       |

*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:** ILIANA MAZE

MGR

04/20/2021

Electronic Signature of Signing Authorized Person(s) Detail

Date