

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

CORPORATION
ANNUAL REPORT
1995



FLORIDA DEPARTMENT OF STATE
Sandra B. Morham
Secretary of State
DIVISION OF CORPORATIONS

APPROVED
AND
FILED

95 MAR -1 PM 1:33

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # 600725 (6)

1. Corporation Name

~~ROBERT H. PARE PROFESSIONAL ASSOCIATION~~
Obstetrics & Gynecology Associates of So. FL, PA

Principal Place of Business

314 HOSPITAL AVENUE
STUART FL 34994-2338

Mailing Address

314 HOSPITAL AVENUE
STUART FL 34994-2338

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified

01/02/1969

3a. Date of Last Report

03/30/1994

4. FEI Number

59-1227509

Applied For

Not Applicable

5. Certificate of Status Desired

☐

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution

☐

\$5.00 May Be
Added to Fees

8. This corporation has liability for intangible tax under S. 199.032,
Florida Statutes: ☒ Yes ☐ No

2. Principal Place of Business

21

2a. Mailing Address

26

Suite, Apt. #, etc.

Suite, Apt. #, etc.

22

27

City & State

City & State

23

28

Zip

Country

Zip

Country

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

THOMSON, ALTON L. M.D.

314 SE HOSPITAL AVE.

STUART FL 34994

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

TITLE

PD

NAME

THOMSON, ALTON L. JR. M

STREET ADDRESS

314 HOSPITAL AVE.

CITY-ST-ZIP

STUART FL

TITLE

VPD

NAME

PARE, ROBERT H. J. M.D.

STREET ADDRESS

314 HOSPITAL AVE.

CITY-ST-ZIP

STUART FL

TITLE

VPD

NAME

PARE, ROBERT H. M

STREET ADDRESS

314 HOSPITAL AVE.

CITY-ST-ZIP

STUART FL

TITLE

SD

NAME

MACKENZIE, ROBERT D. M

STREET ADDRESS

314 SE HOSPITAL AVE.

CITY-ST-ZIP

STUART FL

TITLE

TD

NAME

BOLAND, NEIL C. M

STREET ADDRESS

314 SE HOSPITAL AVE.

CITY-ST-ZIP

STUART FL

TITLE

NAME

STREET ADDRESS

CITY-ST-ZIP

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE

☐ Change ☐ Addition

1.2 NAME

1.3 STREET ADDRESS

1.4 CITY-ST-ZIP

300001419433
-03/02/95--01069--002

***200.00 ***200.00

2.1 TITLE

☐ Change ☐ Addition

2.2 NAME

2.3 STREET ADDRESS

2.4 CITY-ST-ZIP

3.1 TITLE

☒ Change ☐ Addition

3.2 NAME

3.3 STREET ADDRESS

3.4 CITY-ST-ZIP

4.1 TITLE

☐ Change ☐ Addition

4.2 NAME

4.3 STREET ADDRESS

4.4 CITY-ST-ZIP

5.1 TITLE

☐ Change ☐ Addition

5.2 NAME

5.3 STREET ADDRESS

5.4 CITY-ST-ZIP

6.1 TITLE

☐ Change ☐ Addition

6.2 NAME

6.3 STREET ADDRESS

6.4 CITY-ST-ZIP

CH

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 110.07(3)(k), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 007, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Alton L. Thomson

2/22/95

Date

607-287-5590

Telephone #