FILE NOW: FILING FEE IS $61.25

NONPROFIT CORPORATION ANNUAL REPORT **1996**

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

DOCUMENT # **727926** **(8)**

1. Corporation Name

POLK COUNTY MEDICAL ASSOCIATION, INC.

Principal Place of Business	Mailing Address
402 SOUTH KENTUCKY AVE., STE. 350 P. O. BOX 927 LAKELAND FL 33802	402 SOUTH KENTUCKY AVE., STE. 350 P. O. BOX 927 LAKELAND FL 33802

3. Date Incorporated or Qualified: **11/02/1973**
3a. Date of Last Report: **03/15/1995**

2. Principal Place of Business — 21:
2a. Mailing Address — 26:
Suite, Apt. #, etc. — 22:
Suite, Apt. #, etc. — 27:
City & State — 23:
City & State — 28:
Zip — 24: Country — 25:
Zip — 29: Country — 30:

4. FEI Number: **59-6137315** ☐ 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

9. Name and Address of Current Registered Agent

MURPHY, BEVERLY T.
402 S. KENTUCKY
STE. 350
LAKELAND FL 33802

10. Name and Address of New Registered Agent

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 617.0502 and 617.1508, 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 617.0503, Florida Statutes.

SIGNATURE _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating)

12. OFFICERS AND DIRECTORS			13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12		
TITLE	T	☒ DELETE	1.1 TITLE	T	☐ Change ☒ Addition
NAME	MATHEWSON, JOHN J MD		1.2 NAME	ROBERT H. CASSELL, MD	
STREET ADDRESS	402 S. KENTUCKY AVE.		1.3 STREET ADDRESS	402 S KENTUCKY AVE	
CITY-ST-ZIP	LAKELAND FL 33801		1.4 CITY-ST-ZIP	LAKELAND, FL 33801	
TITLE	T	☐ DELETE	2.1 TITLE		☒ Change ☐ Addition
NAME	SCHEMMERN, GARY B MD		2.2 NAME	CORRECT SPELLING	
STREET ADDRESS	402 S. KENTUCKY AVE.		2.3 STREET ADDRESS	GARY B. SCHEMMER, MD	
CITY-ST-ZIP	LAKELAND FL 33801		2.4 CITY-ST-ZIP		
TITLE	T	☐ DELETE	3.1 TITLE		☐ Change ☐ Addition
NAME	HEYSEK, RANDY M MD		3.2 NAME		
STREET ADDRESS	402 S. KENTUCKY AVE.		3.3 STREET ADDRESS		
CITY-ST-ZIP	LAKELAND FL 33801		3.4 CITY-ST-ZIP		
TITLE	D	☐ DELETE	4.1 TITLE		☐ Change ☐ Addition
NAME	MURPHY, BEVERLY T.		4.2 NAME		
STREET ADDRESS	402 S. KENTUCKY, STE 350		4.3 STREET ADDRESS		
CITY-ST-ZIP	LAKELAND FL		4.4 CITY-ST-ZIP		
TITLE		☐ DELETE	5.1 TITLE		☐ Change ☐ Addition
NAME			5.2 NAME		
STREET ADDRESS			5.3 STREET ADDRESS		
CITY-ST-ZIP			5.4 CITY-ST-ZIP		
TITLE		☐ DELETE	6.1 TITLE		☐ Change ☐ Addition
NAME			6.2 NAME		
STREET ADDRESS			6.3 STREET ADDRESS		
CITY-ST-ZIP			6.4 CITY-ST-ZIP		

CR2E037 (12/95)

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 119.07(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 617, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: Beverly T. Murphy BEVERLY T. MURPHY 01/25/96 941 682-0543
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #