


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 10, 2008 08:00 A
Secretary of State


DOCUMENT # J61806
 1. Entity Name
 INTERNATIONAL ANESTHESIOLOGY ASSOCIATES, INC.



Principal Place of Business
 1100 NW 95TH ST
 2ND FLOOR
 MIAMI, FL 33150-2038

Mailing Address
 POST OFFICE BOX 530759
 MIAMI, FL 33153

DO NOT WRITE IN THIS SPACE



02112008 No Chg-P CR2E034 (11/05)

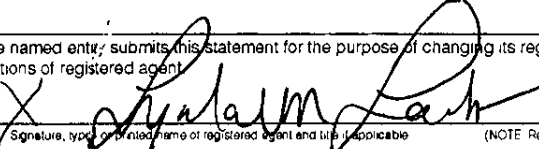
4. FEI Number 59-2816117	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

LAMBERT, LYNDALL
 701 BRICKELL AVENUE
 SUITE 3000
 MIAMI, FL 33131

DO NOT WRITE IN THIS SPACE

8. 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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE:  DATE: 2/22/08

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

FILE NOW!!! FEE IS \$150.00
After May 1, 2008 Fee will be \$550.00

9. Election Campaign Financing Trust Fund Contribution. **\$5.00** May Be Added to Fees

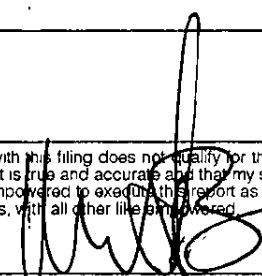
U00000852709
 03/26/08-80039-024 150.00

10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P SCHOU, MICHAEL, MD 4245 LAKE ROAD MIAMI, FL 33137
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP VENDRYES, CHRIS MD 14422 SW 92 COURT MIAMI, FL 33176
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	

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12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report or supplemental 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 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like information.

SIGNATURE:  DATE: 2/22/08

Michael J Schou, MD, Pain Management
1100 NW 95 Str, 2nd floor Pain Center
Miami, Florida 33150-2098
Phone: 305 694 3775, Fax 305 694 3678
E mail: micschou@aol.com

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR