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NONPROFIT CORPORATION ANNUAL REPORT

1996

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

DOCUMENT # N93000005582 (2)

1. Corporation Name

WE CARE PROGRAM OF THE BROWARD COUNTY MEDICAL AS SOCIATION, INC.

Principal Place of Business	Mailing Address
1001 W. CYPRESS CREEK RD. #S207 FT. LAUDERDALE FL 33309 US	1001 W. CYPRESS CREEK RD. #S207 FT. LAUDERDALE FL 33309 US

3. Date Incorporated or Qualified: 12/13/1993

3a. Date of Last Report: 04/18/1995

4. FEI Number: 65-0471317 ☐ 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	2a. Mailing Address
21 5101 nw 21 Ave	26 5101 nw 21 Ave
22 Suite, Apt. #, etc S-440	27 Suite, Apt. #, etc #440
23 City & State fort lauderdale fl	28 City & State fort lauderdale fl
24 Zip 33309 25 Country USA	29 Zip 33309 30 Country USA

9. Name and Address of Current Registered Agent

PETERSON, CYNTHIA S
1001 W. CYPRESS CREEK RD.
STE 207
FT. LAUDERDALE FL 33309

10. Name and Address of New Registered Agent

81 Name: 5101 nw 21 Avenue
82 Street Address (P.O. Box Number is Not Acceptable): S-440
83
84 City: fort lauderdale FL 85 Zip Code: 33309

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 / NAME / STREET ADDRESS / CITY-ST-ZIP	D CLINE, ROBERT M.D. 5601 N. DIXIE HWY. FT. LAUDERDALE FL 33334	☐ DELETE	1.1 TITLE / 1.2 NAME / 1.3 STREET ADDRESS / 1.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D CORLEY, T. EDWARD M.D. ONE W. SAMPLE RD. POMPANO BEACH FL 33064	☐ DELETE	2.1 TITLE / 2.2 NAME / 2.3 STREET ADDRESS / 2.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D OTT, RICHARD M.D. 4801 N. FEDERAL HWY. FT. LAUDERDALE FL 33308	☐ DELETE	3.1 TITLE / 3.2 NAME / 3.3 STREET ADDRESS / 3.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D CATANZANO, ROBERT M 6405 N FED HWY FT LAUDERDALE FL	☐ DELETE	4.1 TITLE / 4.2 NAME / 4.3 STREET ADDRESS / 4.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ DELETE	5.1 TITLE / 5.2 NAME / 5.3 STREET ADDRESS / 5.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ DELETE	6.1 TITLE / 6.2 NAME / 6.3 STREET ADDRESS / 6.4 CITY-ST-ZIP	☐ Change ☐ Addition

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: Robert E Cline MD 4-18-96 954-714-9477
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #