


2004 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 29, 2004 8:00 am
Secretary of State

04-29-2004 90378 001 ***306.25

DOCUMENT # N93000005582

1. Entity Name
WE CARE PROGRAM OF THE BROWARD COUNTY MEDICAL ASSOCIATION, INC.



Principal Place of Business 5101 NW 21 AVENUE SUITE S-440 FORT LAUDERDALE, FL 33309 US	Mailing Address 5101 NW 21 AVENUE SUITE 440 FT. LAUDERDALE, FL 33309 US
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66416704



2. Principal Place of Business Suite, Apt. #, etc.	3. Mailing Address Suite, Apt. #, etc.
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04262004 Chg-NP CR2E037 (10/03)

City & State	City & State
Zip	Country

4. FEI Number 65-0471317	Applied For Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
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6. Name and Address of Current Registered Agent

PETERSON, CYNTHIA S
 5101 NW. 21 AVE
 SUITE S-440
 FT. LAUDERDALE, FL 33309

7. Name and Address of New Registered Agent

Name _____
 Street Address (P.O. Box Number is Not Acceptable) _____
 City _____ **FL** Zip Code _____

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

**Filing Fee is \$61.25
 Due by May 1, 2004**

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

Make check payable to Florida Department of State

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE NAME STREET ADDRESS CITY-ST-ZIP	D CLINE, ROBERT M.D. 5601 N. DIXIE HWY. FT. LAUDERDALE, FL 33334	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD HAMILTON, EDWIN M.D. 2323 NW 19TH STREET FT. LAUDERDALE, FL 33311	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D CATANZANO, ROBERT M 6405 N FED HWY FT LAUDERDALE, FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	TD COX, LINDA MD 510 NW 21ST AVE STE 440 FORT LAUDERDALE, FL 33309	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), 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 617, 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 empowered.

SIGNATURE: *Edwin Hamilton MD* **4-28-04 954-714-9772**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #