

2007 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED

Feb 05, 2007 08:00 AM
Secretary of State

DOCUMENT # P00000013293

1. Entity Name

**THE PREVENTIVE MEDICINE CENTER OF
GAINESVILLE, INC.**



Principal Place of Business
**905 NW 56TH TERR
GAINESVILLE FL 32605**

Mailing Address
**13808 NW 21ST LANE
GAINESVILLE FL 32606**



2. Principal Place of Business - No P.O. Box #

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

1st MOORE

CR2E034 (10/06)

4. FEI Number **59-3627886**

Applied For

Not Applicable

5. Certificate of Status Desired ☒

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

**ERICKSON, ROBERT A M.D.
13808 NW 21ST LANE
GAINESVILLE FL 32606**

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

FILE NOW!!! FEE IS \$150.00
After May 1, 2007 Fee Will Be \$550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

TITLE **D** ☐ Delete
NAME **ERICKSON, ROBERT A M.D.**
STREET ADDRESS **13808 NW 21ST LANE**
CITY- ST- ZIP **GAINESVILLE FL 32606**

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY- ST- ZIP

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CITY- ST- ZIP

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY- ST- ZIP
U000000623912
02/14/07-80009-006 158.75

TITLE ☐ Change ☐ Addition
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CITY- ST- ZIP

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 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 empowered.

SIGNATURE:

[Signature]

ROBERT A. ERICKSON M.D.

1/27/07 352-331538

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #