


**2004 FOR PROFIT CORPORATION ANNUAL REPORT**

**FILED**  
**Feb 27, 2004 08:00 AM**  
**Secretary of State**

DOCUMENT # P01000043357  
 1. Entity Name  
 RADIOLOGY DOCTORS, P.A.



Principal Place of Business  
 NPR COMMUNITY HOSPITAL  
 5622 MARINE PKWY  
 NEW PORT RICHEY, FL 34652

Mailing Address  
 PO BOX 127  
 ELFERS, FL 34680

**DO NOT WRITE IN THIS SPACE**



02132004 No Chg-P CR2E034 (10/03)

4. FEI Number  
 59-3715296

Applied For  
 Not Applicable

5. Certificate of Status Desired  **\$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent  
 WARRILOW, ARTHUR G  
 14209 ASHBURN PLACE  
 TAMPA, FL 33624

**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 \_\_\_\_\_  
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, 2004 Fee will be \$550.00**

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

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	DP BARAT, GUY R M.D. 100 STANTON CIRCLE OLDSMAR, FL 34677
TITLE NAME STREET ADDRESS CITY - ST - ZIP	DVST PARISE, JOSEPH S M.D. 1033 ROYAL BIRKDALE DR TARPON SPRINGS, FL 34688
TITLE NAME STREET ADDRESS CITY - ST - ZIP	
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 02/27/04-80035-009 150.00

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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 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: Joseph S. Parise, MD **JOSEPH S. PARISE, MD** 2/24/02 **2/24/02** (727) 834-5915 **(727) 834-5915**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #