

**2006 FOR PROFIT CORPORATION ANNUAL REPORT**

**FILED**  
**Jan 23, 2006 08:00 AM**  
**Secretary of State**

DOCUMENT # P01000043357



Entity Name  
 BIOLOGY DOCTORS, P.A.

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

Mailing Address  
 PO BOX 127  
 ELFERS, FL 34680



01132006 No Chg-P CR2E034 (11/05)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number 59-3715296	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**

ARRILOW, ARTHUR G  
 109 ASHBURN PLACE  
 WPA, FL 33624

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I, 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

NATURE \_\_\_\_\_ DATE \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when re-registering)

**FILE NOW!!! FEE IS \$150.00**  
**After May 1, 2006 Fee will be \$550.00**

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

1101001347843  
 01/20/06-80066-013 150.00

**OFFICERS AND DIRECTORS**

DP BARAT, GUY R M.D. 100 STANTON CIRCLE OLDSMAR, FL 34677
DVST PARISE, JOSEPH S M.D. 1033 ROYAL BIRKDALE DR TARPON SPRINGS, FL 34688

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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 empowered.

SIGNATURE:

*Joseph S. Parise, MD*  
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/16/06  
 Date

(727)834-5915  
 Daytime Phone #