

**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 26, 2004 08:00 AM
Secretary of State

DOCUMENT # P97000045596

1. Entity Name
ALLIED HEALTHCARE ASSOCIATES, P.A.



Principal Place of Business
**1019 FLAGLER AVENUE
KEY WEST, FL 33040**

Mailing Address
**17196 ALAMANDA DRIVE WEST
SUGARLOAF KEY, FL 33042-3708**



01082004 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number
23-2802407

Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

**MAUST, KEITH E
17196 ALAMANDA DRIVE WEST
SUGARLOAF KEY, FL 33042-3708**

**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
**P/D
KEITH E MAUST
17196 ALAMANDA DRIVE WEST
SUGARLOAF KEY, FL 330423708**

TITLE
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000000067457
02/26/04-80057-020 150.00

**DO NOT WRITE
IN THIS SPACE**

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #