


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 27, 2008 08:00 A
Secretary of State

DOCUMENT # P98000058388

1. Entity Name
SURGERY CENTER OF OKEECHOBEE, INC.



Principal Place of Business Mailing Address
1655 HIGHWAY 441 NORTH **1655 HIGHWAY 441 NORTH**
OKEECHOBEE, FL 34972 US **OKEECHOBEE, FL 34972 US**

DO NOT WRITE IN THIS SPACE



01142008 No Chg-P CR2E034 (11/05)

4. FEI Number Applied For
65-0847931 Not Applicable

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

6. Name and Address of Current Registered Agent

DEC CONSULTANTS, INC.
1515 INDIAN RIVER BLVD
SUITE A-210
VERO BEACH, FL 32960

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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 *Joyfarzous* DATE **3/17/08**

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

FILE NOW!!! FEE IS \$150.00
After May 1, 2008 Fee will be \$550.00

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

U00000872256
 04/16/08-80024-019 150.00

10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD LANZA, JOHN M.D. 200 19TH DRIVE OKEECHOBEE, FL 34972
TITLE NAME STREET ADDRESS CITY-ST-ZIP	STD JAMES, RICHARD M.D. 245 19TH DRIVE OKEECHOBEE, FL 34972
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D CHANG, JOHN M.D. 235 N.E. 19TH DRIVE OKEECHOBEE, FL 34972
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D KURESHI, ZAFAR M.D. 214 N.E. 19TH DRIVE OKEECHOBEE, FL 34972
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D GARCIA, MANUEL M.D. 306 N.E. 19TH DRIVE OKEECHOBEE, FL 34972
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D LEVINE, MARC M.D. P.O. BOX 494H DRIVE OKEECHOBEE, FL 34972

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12. 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: *John Lanza MD* DATE **3/17/08**

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