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PROFIT CORPORATION ANNUAL REPORT 1999

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # V07361

1. Corporation Name

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE, P. A.

Principal Place of Business	Mailing Address
509 RIVERSIDE DR SUITE 302 STUART FL 34994 US	509 RIVERSIDE DR SUITE 302 STUART FL 34994 US

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	2a. Mailing Address
21	26
Suite, Apt. #, etc. 22	Suite, Apt. #, etc. 27
City & State 23	City & State 28
Zip 24 Country 25	Zip 29 Country 30

3. Date Incorporated or Qualifed: 01/16/1992

4. FEI Number: 65-0311858 ☐ Applied For ☐ Not Applicable

5. Certifcate of Status Desired ☐ — $8.75 Additional Fee Required

6. Election Campaign Financing Trust Fund Contribution ☐ — $5.00 May Be Added to Fees

8. This corporation owes the current year Intangible Personal Property Tax. ☒ Yes ☐ No

9. Name and Address of Current Registered Agent	10. Name and Address of New Registered Agent
COEL, MARK A 4000 HOLLYWOOD BLVD. SUITE 350 NORTH HOLLYWOOD FL 33021	81 Name 82 Street Address (P.O. Box Number is Not Acceptable) 83 84 City FL 85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

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

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	PD ☐ DELETE	1.1 TITLE	☐ Change ☐ Addition
NAME	ANSPACH, W.E. III M.D.	1.2 NAME	
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302	1.3 STREET ADDRESS	
CITY-ST-ZIP	STUART FL 34994	1.4 CITY-ST-ZIP	
TITLE	VD ☐ DELETE	2.1 TITLE	☐ Change ☐ Addition
NAME	CARLSON, W.E. M.D.	2.2 NAME	
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302	2.3 STREET ADDRESS	
CITY-ST-ZIP	STUART FL 34994	2.4 CITY-ST-ZIP	
TITLE	SD ☐ DELETE	3.1 TITLE	☐ Change ☐ Addition
NAME	DESMAN, SCOTT M.D.	3.2 NAME	
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302	3.3 STREET ADDRESS	
CITY-ST-ZIP	STUART FL 34994	3.4 CITY-ST-ZIP	
TITLE	TD ☐ DELETE	4.1 TITLE	☐ Change ☐ Addition
NAME	KIM, DAVID M.D.	4.2 NAME	
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302	4.3 STREET ADDRESS	
CITY-ST-ZIP	STUART FL 34994	4.4 CITY-ST-ZIP	
TITLE	☐ DELETE	5.1 TITLE	D ☐ Change ☒ Addition
NAME		5.2 NAME	Haas, George M.D.
STREET ADDRESS		5.3 STREET ADDRESS	509 Riverside Drive Suite 302
CITY-ST-ZIP		5.4 CITY-ST-ZIP	Stuart, FL 34994
TITLE	☐ DELETE	6.1 TITLE	☐ Change ☐ Addition
NAME		6.2 NAME	
STREET ADDRESS		6.3 STREET ADDRESS	
CITY-ST-ZIP		6.4 CITY-ST-ZIP	

14. 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: W.E. CARLSON M.D. 4-13-99 561 223 5980
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034 (11/98)