

**2004 FOR PROFIT CORPORATION
ANNUAL REPORT (AR)**

FILED
Mar 24, 2004 8:00 am
Secretary of State

03-24-2004 90016 011 ***150.00

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1. Entity Name

OB/GYN SPECIALISTS OF THE EMERALD COAST, P.A.

Principal Place of Business

924 MAR WALT DR
FORT WALTON BEACH FL 32547

Mailing Address -

924 MAR WALT DR
FORT WALTON BEACH FL 32547

11060000



MOORE

CR2E034 (11/03)

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number **59-3585016**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

MCINNIS, C. JEFFREY
909 MAR WALT DRIVE
SUITE 1014
FORT WALTON BEACH FL 32547

Name

Street Address (P.O. Box Number is Not Acceptable)

City

FL

Zip Code

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

Make Check Payable to Florida Department of State

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **D** ☐ Delete
NAME **COOLEY, CANDACE M.D.**
STREET ADDRESS **924 MAR WALT DRIVE**
CITY-ST-ZIP **FORT WALTON BEACH FL 32547**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE **VP** ☐ Delete
NAME **ARMBRUSTER, KELLY**
STREET ADDRESS **924 MAR WALT DRIVE**
CITY-ST-ZIP **FORT WALTON BEACH FL 32547**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ Change ☐ Addition
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CITY-ST-ZIP

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:

Candace Cooley MD
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

3-19-04 850 862 1800