



# 2005 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Feb 21, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # K28191</b>	
1. Entity Name VASCULAR SURGERY ASSOCIATES OF NORTH FLORIDA, P.A.	

Principal Place of Business 2140 KINGSLEY AVE. 14 ORANGE PARK, FL 32073 US	Mailing Address 2140 KINGSLEY AVE. 14 ORANGE PARK, FL 32073 US
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**DO NOT WRITE IN THIS SPACE**

	
02082005	No Chg-P CR2E034 (10/03)
4. FEI Number 59-2895258	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  AKEL, EDWARD C 1 INDEPENDENT DR STE 2301 JACKSONVILLE, FL 32202	
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**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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>	DATE _____
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<b>FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00</b>	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b>
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P RIFKIN, KERRY V 2140 KINGSLEY AVE. STE. 14 ORANGE PARK, FL 32073
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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: <u>X</u> 	Kerry V. Rifkin, M.D. (904) 276-7997
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR	Date <u>2/12/05</u> Daytime Phone # _____