

2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 29, 2006 08:00 AM
Secretary of State

DOCUMENT # P98000058388					
1. Entity Name SURGERY CENTER OF OKEECHOBEE, INC.					
Principal Place of Business 1655 HIGHWAY 441 NORTH OKEECHOBEE, FL 34972 US			Mailing Address 1655 HIGHWAY 441 NORTH OKEECHOBEE, FL 34972 US		
2. Principal Place of Business		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country		
6. Name and Address of Current Registered Agent RAPPEL, ROBERT 5070 HWY A1A - STE 221 C/O RAPPEL & RAPHAEL VERO BEACH, FL 32960-4230				7. Name and Address of New Registered Agent 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. NO Change (NOTE: Registered Agent signature required when reinstating) DATE _____					
FILE NOW!!! FEE IS \$150.00 After May 1, 2006 Fee will be \$550.00		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 PD NAME LANZA, JOHN M.D. STREET ADDRESS 200 19TH DRIVE CITY-ST-ZIP OKEECHOBEE, FL 34972	☐ Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition	
TITLE STD NAME JAMES, RICHARD M.D. STREET ADDRESS 245 19TH DRIVE CITY-ST-ZIP OKEECHOBEE, FL 34972	☐ Delete		U000000484486 04/12/06-30044-012 150.00		
TITLE D NAME CHANG, JOHN M.D. STREET ADDRESS 235 N.E. 19TH DRIVE CITY-ST-ZIP OKEECHOBEE, FL 34972	☐ Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition	
TITLE D NAME KURESHI, ZAFAR M.D. STREET ADDRESS 214 N.E. 19TH DRIVE CITY-ST-ZIP OKEECHOBEE, FL 34972	☐ Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition	
TITLE D NAME GARCIA, MANUEL M.D. STREET ADDRESS 306 N.E. 19TH DRIVE CITY-ST-ZIP OKEECHOBEE, FL 34972	☐ Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition	
TITLE D NAME LEVINE, MARC M.D. STREET ADDRESS P.O. BOX 494H DRIVE CITY-ST-ZIP OKEECHOBEE, FL 34972	☐ Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition	
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 as 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			3-24-06 863-357-62 Date Daytime Phone #		