

**2007 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Apr 25, 2007 8:00 am
Secretary of State

04-25-2007 90180 017 ***550.00

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1. Entity Name
NORTH RIDGE INTERNAL MEDICINE ASSOCIATES, P.A.



Principal Place of Business
**5601 NORTH DIXIE HIGHWAY SUITE 412
FORT LAUDERDALE, FL 33334**

Mailing Address
**5601 NORTH DIXIE HIGHWAY SUITE 412
FORT LAUDERDALE, FL 33334**

40080610



02052007 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
65-0955650

Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

**HOMER, KENNETH MD
5601 NORTH DIXIE HIGHWAY SUITE 412
FORT LAUDERDALE, FL 33334**

**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 _____
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, 2007 Fee will be \$550.00**

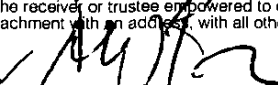
9. Election Campaign Financing
Trust Fund Contribution. ☐ **\$5.00 May Be
Added to Fees**

10. OFFICERS AND DIRECTORS

TITLE	D
NAME	BLOOM, ALLAN MD
STREET ADDRESS	5601 NORTH DIXIE HIGHWAY SUITE 412
CITY-ST-ZIP	FORT LAUDERDALE, FL 33334
TITLE	D
NAME	HOMER, KENNETH MD
STREET ADDRESS	5601 NORTH DIXIE HIGHWAY SUITE 412
CITY-ST-ZIP	FORT LAUDERDALE, FL 33334
TITLE	D
NAME	GUIDA, VINCENT MD
STREET ADDRESS	5601 NORTH DIXIE HIGHWAY SUITE 412
CITY-ST-ZIP	FORT LAUDERDALE, FL 33334
TITLE	D
NAME	SHOOK, JOHN MD
STREET ADDRESS	5601 NORTH DIXIE HWY SUITE 412
CITY-ST-ZIP	FORT LAUDERDALE, FL 33334
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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IN THIS SPACE**

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:  **Allan Bloom, M.D.** 
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #