

**2019 FLORIDA NOT FOR PROFIT CORPORATION ANNUAL REPORT**

DOCUMENT# N98000000967

**FILED**  
**Apr 30, 2019**  
**Secretary of State**  
**1661989720CC**

**Entity Name:** BROWARD COUNTY MEDICAL ASSOCIATION  
PHYSICIAN/EMPLOYEES PROVIDER PLAN, INC.

**Current Principal Place of Business:**

5101 N.W. 21ST AVE.,STE.450  
FT. LAUDERDALE, FL 33309

**Current Mailing Address:**

5101 N.W. 21ST AVE.,STE.450  
FT. LAUDERDALE, FL 33309

**FEI Number: 65-0812616**

**Certificate of Status Desired: No**

**Name and Address of Current Registered Agent:**

PETERSON, CYNTHIA S  
5101 N.W. 21ST AVE.,STE.450  
FT. LAUDERDALE, FL 33309 US

*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.*

**SIGNATURE:**

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**Officer/Director Detail :**

Title PD  
Name PALAMARA, ARTHUR  
Address 1150 N. 35TH AVENUE  
SUITE 460  
City-State-Zip: HOLLYWOOD FL 33021

Title D  
Name ELKIN, AARON M.D.  
Address 5101 NW 21ST AVENUE STE 450  
City-State-Zip: FORT LAUDERDALE FL 33309

Title D  
Name CHANDRAN, KUTTY  
Address 5101 NW 21ST AVENUE  
SUITE 450  
City-State-Zip: FT. LAUDERDALE FL 33309

Title D  
Name HAMILTON, EDWIN  
Address 2323 NW 19TH ST #2  
City-State-Zip: FT. LAUDERDALE FL 33311

*I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 617, Florida Statutes, and that my name appears above, or on an attachment with all other like empowered.*

**SIGNATURE: ARTHUR E. PALAMARA, M.D.**

**PRESIDENT**

**04/30/2019**

\_\_\_\_\_  
Electronic Signature of Signing Officer/Director Detail

\_\_\_\_\_  
Date