

2017 FLORIDA PROFIT CORPORATION ANNUAL REPORT

DOCUMENT# 487397

Entity Name: LAWNWOOD MEDICAL CENTER, INC.**Current Principal Place of Business:**ONE PARK PLAZA
NASHVILLE, TN 37203**Current Mailing Address:**P.O. BOX 750
NASHVILLE, TN 37202 US**FEI Number:** 59-1764486**Certificate of Status Desired:** No**Name and Address of Current Registered Agent:**CT CORPORATION SYSTEM
1200 SOUTH PINE ISLAND ROAD
PLANTATION, FL 33324 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	DP
Name	HAZEN, SAMUEL N
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	DVPA
Name	FRANCK, JOHN M II
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	SVPT
Name	MORROW, J. WILLIAM B.
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	DSVP
Name	WYATT, CHRISTOPHER F
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	VPS
Name	CLINE, NATALIE H
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

Title	VP
Name	GRUBBS, RONALD L JR.
Address	ONE PARK PLAZA
City-State-Zip:	NASHVILLE TN 37203

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 607, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.

SIGNATURE: NATALIE H. CLINE

VPS

04/21/2017

Electronic Signature of Signing Officer/Director Detail_____
Date