


FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Feb 20, 2004 8:00 am
Secretary of State

02-20-2004 90013 004 ***150.00

DOCUMENT # 324331	
Entity Name INTER-MEDIC HEALTH CENTER OF CHARLOTTE, INC.	

Principal Place of Business 2885 TAMiami TRAIL PORT CHARLOTTE FL 33952	Mailing Address 2885 TAMiami TRAIL PORT CHARLOTTE FL 33952
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2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip	Country

4. FEI Number 59-1365533		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 KARCH, MICHAEL T 2885 TAMiami TR PORT CHARLOTTE FL 33952	
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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	DATE

FILE NOW!!! FEE IS \$150.00 After May 1, 2004 Fee will be \$550.00 Make Check Payable to Florida Department of State	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P TORNER, J MD 2885 TAMiami TRAIL PORT CHARLOTTE FL 33952 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T HEAGNEY, MICHAEL MD 2885 TAMiami TRAIL PORT CHARLOTTE FL 33952 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V MELSER, MARK MD 2885 TAMiami TRAIL PORT CHARLOTTE FL 33952 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S AMONTREE, JAMES MD. 1117 SAN MATEO DRIVE PUNTA GORDA FL 33950 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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.	
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SIGNATURE:	2-18-04 941-629-0622
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR	Date Daytime Phone #