

**2006 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 23, 2006 08:00 AM
Secretary of State

DOCUMENT # 455991

1. Entity Name
CLINE CARDIOVASCULAR ASSOCIATES, P.A.



Principal Place of Business
**5601 N DIXIE HWY
209
FORT LAUDERDALE, FL 33334**

Mailing Address
**5601 N DIXIE HWY
209
FORT LAUDERDALE, FL 33334**



03082006 - No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
59-1543384

Applied For
☐ Not Applicable

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

6. Name and Address of Current Registered Agent

**CLINE, ROBERT E. M.D.
5601 N DIXIE HWY
209
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

Robert E. Cline M.D.

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when renewing)

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**

000000478733
04/08/06 00016-021 150.00

10. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
**PDT
CLINE, ROBERT E M.D.
5601 N. DIXIE HIGHWAY, #209
FORT LAUDERDALE, FL 33334**

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

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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:

Robert E. Cline M.D.
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Company Phone #