

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

PROFIT
CORPORATION
ANNUAL REPORT
1996



FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **467031** (1)

1. Corporation Name

CHARLOTTE ORTHOPEDIC CLINIC, P.A.



Principal Place of Business

Mailing Address

**2595 HARBOR BLVD
SUITE #102
PORT CHARLOTTE FL 33952**

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SUITE #102
PORT CHARLOTTE FL 33952**

3. Date Incorporated or Qualified

12/30/1974

3a. Date of Last Report

04/25/1995

2. Principal Place of Business

2a. Mailing Address

21

26

4. FCI Number

59-1563145

Applied For

Not Applicable

22

27

5. Certificate of Status Desired

☐

**\$8.75 Additional
Fee Required**

23

28

6. Election Campaign Financing
Trust Fund Contribution

☐

**\$5.00 May Be
Added to Fees**

24

25

29

30

8. This corporation has liability for intangible tax under s. 199.032,
Florida Statutes ☐ Yes ☐ No

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

**NUELLE, DOUGLAS G, M.D.
2595 HARBOR BLVD STE 102
PORT CHARLOTTE FL 33952**

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

Signature (typed or printed name of registered agent for the filing)

The Registered Agent's signature, required when filing

DATE

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

TITLE **ST** ☐ DELETE
NAME **NUELLE, M.D. D G.**
STREET ADDRESS **17223 ARTHUR AVENUE**
CITY- ST- ZIP **PORT CHARLOTTE FL**

1.1 TITLE **PS** ☒ Change ☐ Addition
1.2 NAME
1.3 STREET ADDRESS
1.4 CITY- ST- ZIP **33948**

TITLE **PS** ☐ DELETE
NAME **KALER, M.D. D J.**
STREET ADDRESS **287 STEBBINS TERRACE**
CITY- ST- ZIP **PORT CHARLOTTE FL**

2.1 TITLE **VT** ☒ Change ☐ Addition
2.2 NAME
2.3 STREET ADDRESS
2.4 CITY- ST- ZIP **33952**

TITLE ☐ DELETE
NAME
STREET ADDRESS
CITY- ST- ZIP

3.1 TITLE ☐ Change ☐ Addition
3.2 NAME
3.3 STREET ADDRESS
3.4 CITY- ST- ZIP

TITLE ☐ DELETE
NAME
STREET ADDRESS
CITY- ST- ZIP

4.1 TITLE ☐ Change ☐ Addition
4.2 NAME
4.3 STREET ADDRESS
4.4 CITY- ST- ZIP

TITLE ☐ DELETE
NAME
STREET ADDRESS
CITY- ST- ZIP

5.1 TITLE ☐ Change ☐ Addition
5.2 NAME
5.3 STREET ADDRESS
5.4 CITY- ST- ZIP

TITLE ☐ DELETE
NAME
STREET ADDRESS
CITY- ST- ZIP

6.1 TITLE ☐ Change ☐ Addition
6.2 NAME
6.3 STREET ADDRESS
6.4 CITY- ST- ZIP

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 or empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: X

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

DOUGLAS G. NUELLE, M.D.

04/10/96

(941) 625-0984

End

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