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PROFIT CORPORATION ANNUAL REPORT

1999

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # 517038

1. Corporation Name

MEDICAL CENTER PHARMACY, INC. OF QUINCY

Principal Place of Business	Mailing Address
306 E JEFFERSON ST QUINCY FL 32351 US	306 E JEFFERSON ST QUINCY FL 32351 US

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualifed: 10/18/1976

2. Principal Place of Business	2a. Mailing Address
21	26
Suite, Apt. #, etc. 22	Suite, Apt. #, etc. 27
City & State 23	City & State 28
Zip 24 Country 25	Zip 29 Country 30

4. FEI Number: 59-1710924 ☐ Applied For ☐ Not Applicable

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

6. Election Campaign Financing Trust Fund Contribution ☐ **$5.00** May Be Added to Fees

8. This corporation owes the current year Intangible Personal Property Tax. ☐ Yes ☐ No

9. Name and Address of Current Registered Agent

MASSEY, LYNN G
203 ALBA AVE
QUINCY FL 32351

10. Name and Address of New Registered Agent

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 _____ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

12. OFFICERS AND DIRECTORS			13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	V	☐ DELETE	1.1 TITLE	☐ Change ☐ Addition
NAME	MASSEY, R L		1.2 NAME	
STREET ADDRESS	105 W JEFFERSON ST		1.3 STREET ADDRESS	
CITY-ST-ZIP	QUINCY FL		1.4 CITY-ST-ZIP	
TITLE	P	☐ DELETE	2.1 TITLE	☐ Change ☐ Addition
NAME	MASSEY, LYNN G.		2.2 NAME	
STREET ADDRESS	203 ALBA AVE.		2.3 STREET ADDRESS	
CITY-ST-ZIP	QUINCY, FL 00000		2.4 CITY-ST-ZIP	
TITLE	TS	☐ DELETE	3.1 TITLE	☐ Change ☐ Addition
NAME	MASSEY, BETTY		3.2 NAME	
STREET ADDRESS	105 W. FEFFERSON ST.		3.3 STREET ADDRESS	
CITY-ST-ZIP	QUINCY, FL 00000		3.4 CITY-ST-ZIP	
TITLE		☐ DELETE	4.1 TITLE	☐ Change ☐ Addition
NAME			4.2 NAME	
STREET ADDRESS			4.3 STREET ADDRESS	
CITY-ST-ZIP			4.4 CITY-ST-ZIP	
TITLE		☐ DELETE	5.1 TITLE	☐ Change ☐ Addition
NAME			5.2 NAME	
STREET ADDRESS			5.3 STREET ADDRESS	
CITY-ST-ZIP			5.4 CITY-ST-ZIP	
TITLE		☐ DELETE	6.1 TITLE	☐ Change ☐ Addition
NAME			6.2 NAME	
STREET ADDRESS			6.3 STREET ADDRESS	
CITY-ST-ZIP			6.4 CITY-ST-ZIP	

14. 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 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 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, with all other like empowered.

SIGNATURE: Lynn Massey SIGNATURE REQUIRED — 3-1-99 — 850-627-7595
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034 (11/98)

Q47352-90050-29
517038

APPLICATION FOR PERMIT RENEWAL UNDER CHAPTER 499, F.S.

BUREAU OF PHARMACY SERVICES, FLORIDA DEPARTMENT OF HEALTH

This application form provides information as required by the Florida Drug and Cosmetic Act, Chapter 499, Florida Statutes.

PERMIT TO BE RENEWED: **24:00066 RETAIL PHARMACY WHOLESALER**
EXPIRATION DATE: **3/31/99**

MAILING ADDRESS:
MEDICAL CENTER PHARMACY
306 EAST JEFFERSON STREET
QUINCY, FL 32351

PERMIT & PHYSICAL ADDRESS:
306 EAST JEFFERSON STREET
QUINCY, FL 32351

TELEPHONE: **(850) 627-7595**
OPERATING HOURS: **09:00 - 05:30**

CONTACT IN CASE OF EMERGENCY: **LYNN & TERRANCE G. MASSEY (904)875-3487**
Provide residence address and residence telephone number for a contact person if this information has changed from your last application:_____

IF THERE HAS BEEN A CHANGE IN OWNERSHIP, THIS PERMIT CANNOT BE RENEWED. A NEW PERMIT IS REQUIRED.

Provide correct information above if any change has occurred in the company name, mailing address, physical address, telephone number or operating hours

✓ There have been no changes to the owners, partners or corporate officers. OR
___ There has been a change in the partners or corporate officers. (Attach current information: names, positions, dates of birth.)

SINCE YOUR PREVIOUS APPLICATION WAS SUBMITTED, HAS THE APPLICANT, OWNER(S), MANAGER(S)-IN-CHARGE, ANY OFFICERS, AND/OR ANY EMPLOYEES:	YES	NO
1. Been found guilty (regardless of adjudication) or pled nolo contendere in a court in Florida or any other jurisdiction of a violation of law that directly relates to a drug, device, or cosmetic?	___	✓
2. Been fined or disciplined by a regulatory agency in any state (including Florida) for any offense that would constitute a violation of Chapter 499, F.S.?	___	✓
3. Been convicted of any felony under a federal, state, or local law?	___	✓
4. Had any current or previous permit or license suspended or revoked which was issued by a federal, state or local governmental agency relating to the manufacture or distribution of drugs, devices, or cosmetics?	___	✓
5. Been denied a permit or license related to an activity regulated under Chapter 499, F.S., in any state?	___	✓

ANY "YES" RESPONSE MUST BE DISCUSSED ON AN ATTACHED SHEET.

OUT-OF-STATE PRESCRIPTION-DRUG WHOLESALERS ONLY:
Current valid license number in resident state: _____ Expires: _____ **(Attach a copy of the current permit.)**

RETAIL PHARMACY WHOLESALERS ONLY:
Current valid Community Pharmacy Permit # _____ Expires: _____ **(Attach a copy of the current permit.)**

REMIT: $100.00 If you have multiple manufacturing permits, only pay for the one with the highest fee. The others are complimentary.
IF NOT POSTMARKED BY 3/31/99 YOU MUST INCLUDE A $100 DELINQUENT FEE.
Changes in the Physical Address of a Retail Pharmacy Wholesaler, Out-Of-State Prescription Drug Wholesaler, or Complimentary Drug Distributor located outside of Florida require an **additional $25**. Other permittees should call a local Pharmacy Services Drug Agent or the Tallahasse office to arrange for an ON-SITE INSPECTION. **Applicable Change of Address fees are required** [see Rule 64F-12.018(4)(formerly10D-45.0544(4))].

Make check payable to: Florida Drugs, Devices, and Cosmetics Trust Fund.
Mail to: DOH Bureau of Pharmacy Services (HSFP) 2818-A Mahan Drive, Tallahassee, Florida 32308 Telephone (850) 487-1257

AFFIDAVIT I do solemnly swear and affirm that I have read and agree to comply with Chapter 499, Florida Statutes, and the rules adopted thereunder; that changes to information reflected on previous applications, if not reported on this application, will be communicated in writing to the department prior to the change; that I am the person authorized to sign this application; and that all statements made on this sheet and _____ page(s) of attachments are true and correct in all respects.

_____ _____ _____
Signature of Owner or Corporate Officer Title Date

State of _____
County of _____
STAMP OR SEAL:

Sworn to and subscribed before me this _____ day of _____, 19_____, and
_____ is ___ personally known by me OR
(Print name of person under oath.) has ___ produced _____ as identification.

Commission #_____ _____
Expiration Date: _____ Notary Public's Signature
Print Notary's Name here: _____

DOH-FORM 1034, JANUARY 1997 CHECK NUMBER & AMOUNT _____