


**2007 FOR PROFIT CORPORATION ANNUAL REPORT**

**FILED**  
**Feb 09, 2007 8:00 am**  
**Secretary of State**

02-09-2007 90020 014 \*\*\*158.75

**DOCUMENT # 600805**

1. Entity Name  
 CHILDREN'S MEDICAL GROUP, P.A.



Principal Place of Business  
 4131 UNIVERSITY BLVD., S.  
 JACKSONVILLE, FL 32216-4316

Mailing Address  
 4131 UNIVERSITY BLVD., S.  
 JACKSONVILLE, FL 32216-4316

2. Principal Place of Business - No P.O. Box #  
 Suite, Apt. #, etc.

3. Mailing Address  
 Suite, Apt. #, etc.

City & State  
 City & State

Zip Country  
 Zip Country

01032007 Chg-P CR2E034 (12/06)

4. FEI Number  
 59-1230099 Applied For  
 Not Applicable

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



6. Name and Address of Current Registered Agent

OSTERGREN, KAREN A.  
 4131 UNIVERSITY BLVD., S.  
 JACKSONVILLE, FL 32211

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

**FILE NOW!!! FEE IS \$150.00 After May 1, 2007 Fee will be \$550.00**

9. Election Campaign Financing Trust Fund Contribution.  **\$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP OSTERGREN, KAREN A. 4131 UNIVERSITY BLVD S JACKSONVILLE, FL <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	PD ZIMMERMAN, DALE F, M.D. 4131 UNIVERSITY BLVD.,S. JACKSONVILLE, FL <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	<del>VP</del> VP FAUTH, SCOTT T., M.D. 4131 UNIVERSITY BLVD.,S. JACKSONVILLE, FL <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 WHITE, SUSAN H. 4131 UNIVERSITY BLVD. S. JACKSONVILLE, FL <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 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 of 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: Dale J. Fauth President 2/02/07  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

904 268-6725  
 Date Daytime Phone #