
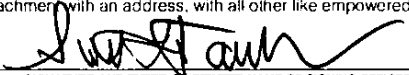


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 24, 2008 8:00 am
Secretary of State

01-24-2008 90036 019 ***158.75

DOCUMENT # 600805					
1. Entity Name CHILDREN'S MEDICAL GROUP, P.A.					
Principal Place of Business 4131 UNIVERSITY BLVD., S. #16 JACKSONVILLE, FL 32216-4316		Mailing Address 4131 UNIVERSITY BLVD., S. #16 JACKSONVILLE, FL 32216-4316			
2. Principal Place of Business - No P.O. Box #		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State		4. FEI Number 59-1230099	
Zip		Country		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent			7. Name and Address of New Registered Agent		
OSTERGREN, KAREN A. 4131 UNIVERSITY BLVD., S. #16 JACKSONVILLE, FL 32211 32216			Name		
			Street Address (P.O. Box Number is Not Acceptable)		
			City		FL
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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when re-registering)</small>					
FILE NOW!!! FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees			
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE	VP	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	OSTERGREN, KAREN A.		NAME		
STREET ADDRESS	4131 UNIVERSITY BLVD S #16		STREET ADDRESS		
CITY-ST-ZIP	JACKSONVILLE, FL 32216		CITY-ST-ZIP		
TITLE	PD	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	ZIMMERMAN, DALE F, M.D.		NAME		
STREET ADDRESS	4131 UNIVERSITY BLVD., S. #16		STREET ADDRESS		
CITY-ST-ZIP	JACKSONVILLE, FL 32216		CITY-ST-ZIP		
TITLE	VP	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	FAUTH, SCOTT T., M.D.		NAME		
STREET ADDRESS	4131 UNIVERSITY BLVD., S. #16		STREET ADDRESS		
CITY-ST-ZIP	JACKSONVILLE, FL 32216		CITY-ST-ZIP		
TITLE	T	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	WHITE, SUSAN H.		NAME		
STREET ADDRESS	4131 UNIVERSITY BLVD. S. #16		STREET ADDRESS		
CITY-ST-ZIP	JACKSONVILLE, FL 32216		CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
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: 				Date: _____	
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR				Daytime Phone #: 904 733-7408	