


**2005 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Apr 13, 2005 8:00 am
Secretary of State

04-13-2005 90049 021 ***150.00

DOCUMENT # 601126 1. Entity Name ATLANTIC COAST PEDIATRICS, M.D., P.A.	
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Principal Place of Business 867 N COURTENAY PKWY MERRITT ISLAND, FL 32953 US	Mailing Address PO BOX 541216 MERRITT ISLAND, FL 32954-1216 US
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DO NOT WRITE IN THIS SPACE



03292005 No Chg-P CR2E034 (10/03)

4. FEI Number 59-1263689	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

GONZALEZ, LUIS A
867 N COURTENAY PKWY
MERRITT ISLAND, FL 32953

**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 _____ 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, 2005 Fee will be \$550.00**

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

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P GONZALEZ, LUIS A 867 N COURTENAY PKWY MERRITT ISLAND, FL 32953
TITLE NAME STREET ADDRESS CITY-ST-ZIP	STVP COSGROVE, LISA A 867 N COURTENAY PKWY MERRITT ISLAND, FL 32953
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12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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: Lisa A. Cosgrove LISA A. COSGROVE, M.D. 4/11/2005 (321)452-1061
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #