

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

CORPORATION  
ANNUAL REPORT  
1995



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

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS

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DOCUMENT # 602946 (6)  
1. Corporation Name  
ANESTHESIOLOGISTS OF CENTRAL FLORIDA, M.D., P.A.

Principal Place of Business Mailing Address  
100 WEST LUCERNE CIRCLE, SUITE 502 100 WEST LUCERNE CIRCLE, SUITE 502  
POST OFFICE BOX 4985 POST OFFICE BOX 4985  
ORLANDO FL 32802-1985 ORLANDO FL 32802-4985  
US

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified 07/08/1971 3a. Date of Last Report 01/21/1994  
4. FEI Number 59-1352993 Applied For Not Applicable  
5. Certificate 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 has liability for intangible tax under S. 199.032, Florida Statutes ☐ Yes ☐ No

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

9. Name and Address of Current Registered Agent  
MURBACH, ROGER S. M  
100 W. LUCERNE CR., SUITE 502  
ORLANDO FL 32801

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

Signature, typed or printed name of registered agent and this if applicable.

(NOTE: Registered Agent signature required when reconstituting)

DATE

12. OFFICERS AND DIRECTORS  
TITLE P B  
NAME MURBACH, ROGER S. M  
STREET ADDRESS P.O. BOX 4985 100 W. LUCERNE CIR. #502  
CITY-ST-ZIP ORLANDO FL  
TITLE SD  
NAME FINER, PAUL M. M  
STREET ADDRESS P.O. BOX 4985, 100 W. LUCERNE CR. #502  
CITY-ST-ZIP ORLANDO FL  
TITLE TD  
NAME GEWOLB, JAY D. M  
STREET ADDRESS P.O. BOX 4985, 100 W. LUCERNE CR #4895  
CITY-ST-ZIP ORLANDO FL  
TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12  
1.1 TITLE ☐ Change ☐ Addition  
1.2 NAME  
1.3 STREET ADDRESS  
1.4 CITY-ST-ZIP  
2.1 TITLE ☐ Change ☐ Addition  
2.2 NAME  
2.3 STREET ADDRESS  
2.4 CITY-ST-ZIP  
3.1 TITLE ☐ Change ☐ Addition  
3.2 NAME  
3.3 STREET ADDRESS  
3.4 CITY-ST-ZIP  
4.1 TITLE ☐ Change ☐ Addition  
4.2 NAME  
4.3 STREET ADDRESS  
4.4 CITY-ST-ZIP  
5.1 TITLE ☐ Change ☐ Addition  
5.2 NAME  
5.3 STREET ADDRESS  
5.4 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)(b), 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 in an addendum with no field.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF FILING OFFICER OR DIRECTOR

Roger S. Murbach, M.D.

1-12-95  
Date

(407) 246-0034  
Telephone Number