


2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Feb 27, 2004 8:00 am
Secretary of State

02-27-2004 90021 001 ***150.00

DOCUMENT # 604569	
1. Entity Name NORTH RIVER FAMILY HEALTH CENTER, P.A.	

Principal Place of Business 606 4TH AVENUE, WEST PALMETTO, FL 34221-5295 US	Mailing Address 606 4TH AVENUE, WEST PALMETTO, FL 34221-5295 US
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2. Principal Place of Business Suite, Apt. #, etc.		3. Mailing Address Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



02242004 Chg-P CR2E034 (10/03)

6. Name and Address of Current Registered Agent KRULL, DAVID J. M.D. 606 4TH AVENUE, WEST PALMETTO, FL 34221-5295	
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7. Name and Address of New Registered Agent Name DAVID J. KRULL, M.D. Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code 34221-5295	
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 David J. Krull, M.D. <i>David J. Krull</i> 02/24/04 <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reappointing)</small> DATE	

FILE NOW!!! FEE IS \$150.00 After May 1, 2004 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VST KRULL, DAVID 2208 8TH ST W PALMETTO, FL 00000, <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	DAVID KRULL, M.D. 34221 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P RAITZ, RAYMOND 4106 POMPANO LANE PALMETTO, FL 00000, <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Raymond Raitz, M.D. 34221 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V BRILES, JAMES A M.D. 240 BAYSHORE DRIVE TERRA CEIA, FL 34250 <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	V LIPSCOMB, KEVIN P M.D. 7605 ALHAMBRA DRIVE BRADENTON, FL 34209 <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	V HEMMER, ANTHONY R M.D. 13611 E. 11TH TERRACE BRADENTON, FL 34212 <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 exemption stated in Section 119.07(3)(i), 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: Raymond L. Raitz, M.D. PRESIDENT <i>Raymond L. Raitz</i> 02/24/04 941-722-7785 <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small> DATE Daytime Phone #	