

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

PROFIT
CORPORATION
ANNUAL REPORT
1996



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

DOCUMENT # 640836 (3)

1. Corporation Name

PALM BEACH ONCOLOGY - HEMATOLOGY, P.A.



Principal Place of Business

1117 N. OLIVE AVE
SUITE 201
WEST PALM BEACH FL 33401

Mailing Address

1117 N. OLIVE AVE
SUITE 201
WEST PALM BEACH FL 33401

2. Principal Place of Business

21 Suite, Apt. #, etc.

22 City & State

23 Zip

25 Country

2a. Mailing Address

26 Suite, Apt. #, etc.

27 City & State

28 Zip

30 Country

3. Date Incorporated or Qualified
09/07/1979

3a. Date of Last Report
04/26/1995

4. FEI Number
59-1908371

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

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

HARRIS, JAMES N., M.D.
1117 N OLIVE AVE
WEST PALM BEACH FL 33401

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]

James N. Harris, M.D., President

4/29/96

Signature typed or printed name of registered agent and the corporation

(If the Registered Agent signature is required when registering)

DATE

12. OFFICERS AND DIRECTORS

TITLE	PD	<input type="checkbox"/> DELETE
NAME	HARRIS, JAMES N., M.D.	
STREET ADDRESS	1117 N OLIVE AVE	
CITY - ST - ZIP	W. PALM BEACH FL	
TITLE	SD	<input type="checkbox"/> DELETE
NAME	MCKEEN, ELISABETH, MD	
STREET ADDRESS	1117 N OLIVE AVE	
CITY - ST - ZIP	W PALM BEACH FL	
TITLE	TD	<input type="checkbox"/> DELETE
NAME	ROTHSCHILD, NEAL, MD	
STREET ADDRESS	1117 N OLIVE AVE	
CITY - ST - ZIP	W PALM BEACH FL	
TITLE	D	<input type="checkbox"/> DELETE
NAME	SCHWARTZ, AUGUSTINE, MD	
STREET ADDRESS	1117 N OLIVE AVE	
CITY - ST - ZIP	W PALM BEACH FL	
TITLE		<input type="checkbox"/> DELETE
NAME		
STREET ADDRESS		
CITY - ST - ZIP		
TITLE		<input type="checkbox"/> DELETE
NAME		
STREET ADDRESS		
CITY - ST - ZIP		

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
1.2 NAME	
1.3 STREET ADDRESS	
1.4 CITY - ST - ZIP	
2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
2.2 NAME	
2.3 STREET ADDRESS	
2.4 CITY - ST - ZIP	
3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
3.2 NAME	
3.3 STREET ADDRESS	
3.4 CITY - ST - ZIP	
4.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
4.2 NAME	Schwartz, Augustin, MD
4.3 STREET ADDRESS	
4.4 CITY - ST - ZIP	
5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
5.2 NAME	
5.3 STREET ADDRESS	
5.4 CITY - ST - ZIP	
6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> 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)(k), 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 or empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 12 or Block 13 of this report, or on an attachment with an address.

SIGNATURE:

[Signature]

Neal Rothschild, M.D., Treasurer

4/29/96

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

CR2E034 (12/95)