

**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 08, 2004 8:00 am
Secretary of State

02-25-2004 90060 020 ***150.00

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1. Entity Name
BAY AREA UROLOGICAL ASSOCIATES, P.A.



Principal Place of Business
**500 VONDERBURG DR.
201E
BRANDON, FL 33511 US**

Mailing Address
**500 VONDERBURG DR.
201E
BRANDON, FL 33511 US**

66404778



02142004 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-1960868	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

**ROBERT KARP
16306 VILLAREAL DRIVE
TAMPA, FL 33613**

**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

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

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00
After May 1, 2004 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	PD KARP, ROBERT L M.D. 500 VONDERBURG BRANDON, FL
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V ALVER, JAMES E M.D. 500 VONDERBURG BRANDON, FL
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST PAOLA, ANGELO S M.D. 500 VONDERBURG BRANDON, FL
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	

**DO NOT WRITE
IN THIS SPACE**

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:

James F. Hues, M.D.
James F. Hues, M.D. **3-4-04** **813-685-0827**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #