


**2008 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED

**Jan 14, 2008 08:00 AM
Secretary of State**

DOCUMENT # 645343	
1. Entity Name DR. JAMES A. CHRISTENSEN M.D., F.A.C.S., P.A.	

Principal Place of Business 4600 N. HABANA, SUITE #21 TAMPA, FL 33614	Mailing Address 4600 N. HABANA, SUITE #21 TAMPA, FL 33614
---	---



01032008 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-1948900	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 CHRISTENSEN, JAMES A. 4600 N. HABANA SUITE #21 TAMPA, FL 33614
--

**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.

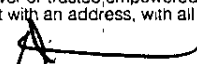
SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	U000000783044 01/15/08-80100-001 150 00
---	--	--

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PD CHRISTENSEN, JAMES A. 4600 N. HABANA TAMPA, FL
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D CHRISTENSEN, MARILYN D. 4600 N. HABANA TAMPA, FL
TITLE NAME STREET ADDRESS CITY - ST - ZIP	
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 exemptions contained in Chapter 119, 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:  **President** **1/4/2007 (813)877-8201**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR **JAMES A. CHRISTENSEN, M.D.** Date Daytime Phone #