


**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 05, 2004 08:00 AM
Secretary of State

DOCUMENT # 661630 1. Entity Name MIAMI MEDICAL CONSULTANTS, P.A.	
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Principal Place of Business 4950 LE JEUNE ROAD H MIAMI, FL 33155	Mailing Address 4950 LE JEUNE ROAD H MIAMI, FL 33155
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02042004 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-1988093	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 CAVA, ROBERT 1200 SW 2ND AVE. MIAMI, FL E, FL 33130	DO NOT WRITE IN THIS SPACE
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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.

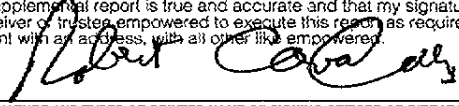
SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____
Signature, typed or printed name of registered agent and title if applicable.

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	000000076892 03/05/04-80020-023 150.00
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	VD CAVA, ROBERT 4950 LEJEUNE ROAD H MIAMI, FL 33146
TITLE NAME STREET ADDRESS CITY - ST - ZIP	
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**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)(f), 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:  **SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR** Date _____ Daytime Phone # _____