


**2007 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 09, 2007 08:00 A
Secretary of State

DOCUMENT # 662998 1. Entity Name S. ANTHONY WOLFE, M.D., P.A.	
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Principal Place of Business 6280 SUNSET DRIVE # 400 SOUTH MIAMI, FL 33143	Mailing Address 6280 SUNSET DRIVE # 400 SOUTH MIAMI, FL 33143
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01302007 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-2002310	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 WOLFE, S. ANTHONY MD 6280 SUNSET DRIVE # 400 SOUTH MIAMI, FL 33143

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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, 2007 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	U00000661777 03/20/07-80055-010 150.00
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DP WOLFE, S. ANTHONY, MD., P.A. 6280 SUNSET DRIVE # 400 SOUTH MIAMI, FL 33143
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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: *S. Anthony Wolfe MD* 03/01/07
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #