


2007 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 31, 2007 8:00 am
Secretary of State

01-31-2007 90035 010 ****61.25

DOCUMENT # 700396		
1. Entity Name HIGHLANDS COUNTY MEDICAL SOCIETY, INC.		

Principal Place of Business PO BOX 310 AVON PARK, FL 33826 US	Mailing Address PO BOX 310 AVON PARK, FL 33826 US
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40000000



2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

01072007 Chg-NP CR2E037 (12/06)

4. FEI Number 23-7026260	Applied For Not Applicable
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5. Certificate of Status Desired ☐ \$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent		7. Name and Address of New Registered Agent	
PAHK, KYE C 6801 US 27 N, STE C-2 SEBRING, FL 33870		Name	
		Street Address (P.O. Box Number is Not Acceptable)	
		City	
		FL Zip Code	

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 _____

Filing Fee is \$61.25
Due by May 1, 2007

9. Election Campaign Financing
Trust Fund Contribution. ☐ \$5.00 May Be Added to Fees

Make check payable to
Florida Department of State

10. OFFICERS AND DIRECTORS				11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10			
TITLE	PD	<input checked="" type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	UPODHYAYA, D.M MD			NAME			
STREET ADDRESS	6801 US 27 N			STREET ADDRESS			
CITY-ST-ZIP	SEBRING, FL 33870			CITY-ST-ZIP			
TITLE	VD	<input type="checkbox"/> Delete		TITLE	PD	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	LEE, KEVIN K MD			NAME			
STREET ADDRESS	3435 S HIGHLANDS AVE			STREET ADDRESS			
CITY-ST-ZIP	SEBRING, FL 33870			CITY-ST-ZIP			
TITLE	STD	<input checked="" type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	FOUFFARD, AMADA S MD			NAME			
STREET ADDRESS	P.O. BOX 837			STREET ADDRESS			
CITY-ST-ZIP	AVON PARK, FL 33826			CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE	VD	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition	
NAME				NAME	VERNON MORRIS, MD		
STREET ADDRESS				STREET ADDRESS	2373 US HWY 27 SOUTH		
CITY-ST-ZIP				CITY-ST-ZIP	SEBRING, FL 33870		
TITLE		<input type="checkbox"/> Delete		TITLE	STD	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition	
NAME				NAME	AMIT K. SHAH, MD		
STREET ADDRESS				STREET ADDRESS	4420 SUN 'N LAKE BLVD.		
CITY-ST-ZIP				CITY-ST-ZIP	SEBRING, FL 33872		
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			

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 617, 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: _____

Kevin K. Lee, MD 1/15/07 863-382-0909