FILE NOW: FILING FEE AFTER MAY 1 IS $155.00

CORPORATION ANNUAL REPORT 1995

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
95 MAY -1 PM 12:26

DOCUMENT # 704949 (7)

1. Corporation Name

FLORIDA PSYCHIATRIC SOCIETY, A DISTRICT BRANCH O F THE AMERICAN PSYCHIATRIC ASSOCIATION, INC.

Principal Place of Business	Mailing Address
521 E. PARK AVENUE TALLAHASSEE FL 32301-9524	521 E. PARK AVENUE TALLAHASSEE FL 32301-9524

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified: 12/18/1962
3a. Date of Last Report: 08/10/1994
4. FEI Number: 59-1735183 ☐ Applied For ☐ Not Applicable

2. Principal Place of Business (21)	2a. Mailing Address (26)	5. Certificate of Status Desired ☐ — $8.75 Additional Fee Required
Suite, Apt. #, etc. (22)	Suite, Apt. #, etc. (27)	6. Election Campaign Financing Trust Fund Contribution ☐ — $5.00 May Be Added to Fees
City & State (23)	City & State (28)	7. Nonprofit with IRS 501(c)(3) Tax Exempt Status ☐ — $68.75 Supplemental Fee Not Required
Zip (24) / Country (25)	Zip (29) / Country (30)	8. This corporation has liability for intangible tax under S. 199.032, Florida Statutes ☐ Yes ☐ No

9. Name and Address of Current Registered Agent	10. Name and Address of New Registered Agent
MARGO S, ADAMS 521 E. PARK AVENUE TALLAHASSEE FL 32301	81 Name 82 Street Address (P.O. Box Number is Not Acceptable) 83 84 City FL 85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with and accept the obligations of Section 607.0505, Florida Statutes.

SIGNATURE: Margo S. Adams — 4/26/95
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) (DATE)

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12		
TITLE	TD	11 TITLE		☑ Change ☐ Addition
NAME	~~EUGENE VALENTINE~~	12 NAME	Phillip Cushman, MD	
STREET ADDRESS	~~571 L OMBRE CIRCLE~~	13 STREET ADDRESS	2830 NW 41ST STREET, #E	
CITY-ST-ZIP	~~FT WALTON BCH FL~~	14 CITY-ST-ZIP	Gainesville, FL 32606	
TITLE	PED	21 TITLE		☑ Change ☐ Addition
NAME	~~BENSON, R. SCOTT~~	22 NAME	Ross A. McElroy, MD	
STREET ADDRESS	~~5100 BAYOU BLVD.~~	23 STREET ADDRESS	J.H. Miller Health Center	
CITY-ST-ZIP	~~PENSACOLA FL~~	24 CITY-ST-ZIP	Gainesville, FL 32610	
TITLE	PD	31 TITLE		☑ Change ☐ Addition
NAME	~~GELFARD, FRANCINE~~	32 NAME	R. Scott Benson, MD	
STREET ADDRESS	~~1200 W DIXIE~~	33 STREET ADDRESS	5100 Bayou Blvd. Building 6	
CITY-ST-ZIP	~~LEESBURG FL~~	34 CITY-ST-ZIP	Pensacola, FL 32507	
TITLE	SD	41 TITLE		☑ Change ☐ Addition
NAME	~~MARIAN LEVAI~~	42 NAME	David Gross, MD	
STREET ADDRESS	~~3745 PLYWOOD TRAIL~~	43 STREET ADDRESS	16244 S. Military Trail	
CITY-ST-ZIP	~~JACKSONVILLE FL~~	44 CITY-ST-ZIP	Delray Beach, FL	
TITLE	VD	51 TITLE		☑ Change ☐ Addition
NAME	~~MCELROY, ROSS~~	52 NAME	Theodor Bonstelle, MD	
STREET ADDRESS	~~J.H. MILLER HEALTH CENTER~~	53 STREET ADDRESS	6070 Anchorline Drive	
CITY-ST-ZIP	~~GAINESVILLE FL~~	54 CITY-ST-ZIP	Fort Myers, FL	
TITLE		61 TITLE		☐ Change ☐ Addition
NAME		62 NAME		
STREET ADDRESS		63 STREET ADDRESS		
CITY-ST-ZIP		64 CITY-ST-ZIP		

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: [signature] Phillip W. Cushman, MD 4.27.95 904-372-0387
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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