

May. 1. 2007 10:26AM

**2007 NOT-FOR-PROFIT CORPORATION
ANNUAL REPORT**

FILED
May 02, 2007 8:00 am
Secretary of State

05-02-2007 90076 015 ****70.00

DOCUMENT #747312			
1. Entity Name THOMAS H. WALLIS M.D., MEDICAL CENTER ASSOCIATION, INC.			
Principal Place of Business 40 SW 12TH ST C202 OCALA, FL 34474 US		Mailing Address 40 SW 12TH ST C202 OCALA, FL 34474 US	
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
4. FEI Number 58-2041410		Applied For Not Applicable	
5. Certificate of Status Desired ☒		\$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent TROW, CHESTER J 40 SW 12TH ST OCALA, FL 32670		7. Name and Address of New Registered Agent 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 _____ DATE _____ Signature, typed or printed name of registered agent and state it affords. (NOTE: Registered Agent signature required when registering)			
Filing Fee is \$61.25 Due by May 1, 2007		9. Election Campaign Financing Trust Fund Contribution. ☐ \$5.00 May Be Added to Fees	
10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10	
TITLE NAME STREET ADDRESS CITY-STATE-ZIP	SD SABOL, EDWARD D 40 SW 12TH ST OCALA, FL 34474 ☐ Delete	TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-STATE-ZIP	MD BALD, CHRISTOPHER 40 SW 12TH ST STE C202 OCALA, FL 34474 ☐ Delete	TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-STATE-ZIP	PD SEYMORE, JAMES 40 SW 12TH STREET, STE B-102 OCALA, FL 34474 ☐ Delete	TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-STATE-ZIP	☐ Change ☐ Addition
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 817, 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: _____		christopher E. Bald, M.D. 5/01/07 352-7325042	
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR		Date Daytime Phone #	