

# 2007 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Jun 25, 2007 8:00 am**  
**Secretary of State**

06-25-2007 90001 050 \*\*\*\*61.25

**DOCUMENT # 762162**

1. Entity Name  
**NORTHWEST MEDICAL CENTER MEDICAL STAFF, INC.**



**40121524**

Principal Place of Business  
**2801 N. STATE ROAD 7  
MARGATE, FL 33063 US**

Mailing Address  
**2801 N. STATE ROAD 7  
MARGATE, FL 33063 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

06192007 Chg-NP CR2E037 (12/06)

4. FEI Number  
**59-2125659**

Applied For  
Not Applicable

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent

**FOSTER, STEVEN M.D.  
2801 N. STATE ROAD 7  
MARGATE, FL 33063**

7. Name and Address of New Registered Agent

Name **LIEF, MATTHEW M.D.**

Street Address (P.O. Box Number is Not Acceptable)

**2801 N. STATE ROAD 7**

City **MARGATE**

FL

Zip Code  
**33063**

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

**MATTHEW LIEF, M.D.**

**6/22/07**

DATE

**Filing Fee is \$61.25  
Due by September 14, 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

TITLE **P** ☒ Delete  
NAME **FOSTER, STEVEN M.D.**  
STREET ADDRESS **2801 N. STATE ROAD 7**  
CITY-ST-ZIP **MARGATE, FL 33063**

TITLE **VP** ☐ Delete  
NAME **GACH, PETER M.D.**  
STREET ADDRESS **2801 N. STATE ROAD 7**  
CITY-ST-ZIP **MARGATE, FL 33063**

TITLE **T** ☐ Delete  
NAME **WEINER, DOUGLAS M.D.**  
STREET ADDRESS **2801 N. STATE ROAD 7**  
CITY-ST-ZIP **MARGATE, FL 33063**

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE **SEC/TREAS** ☐ Change ☒ Addition  
NAME **LIEF, MATTHEW M.D.**  
STREET ADDRESS **2801 N. STATE ROAD 7**  
CITY-ST-ZIP **MARGATE, FL 33063**

TITLE **PRES** ☒ Change ☐ Addition  
NAME **GACH, PETER M.D.**  
STREET ADDRESS **2801 N. STATE ROAD 7**  
CITY-ST-ZIP **MARGATE, FL 33063**

TITLE **VP** ☒ Change ☐ Addition  
NAME **WEINER, DOUGLAS M.D.**  
STREET ADDRESS **2801 N. STATE ROAD 7**  
CITY-ST-ZIP **MARGATE, FL 33063**

TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**MATTHEW LIEF, M.D.**

**6/22/07**

Date

**(954) 494-5196**

Daytime Phone #