

**FILE ON OR BEFORE DECEMBER 31, 1996 OR PARTNERSHIP WILL BE SUBJECT TO REVOCATION AND \$500 PENALTY FEE**

FILED

96 OCT -7 AM 11:42

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

LIMITED PARTNERSHIP  
ANNUAL REPORT  
1997



FLORIDA DEPARTMENT OF STATE  
**Sandra Mortham**  
Secretary of State  
DIVISION OF CORPORATIONS

1. Name of Limited Partnership

1a. DOCUMENT #  
**A10375**

**GOLD COAST MEDICAL ASSOCIATES, LTD.**

*97-AR  
CM*



Mailing Address  
16401 N.W. 2ND AVE.  
SUITE 204  
NORTH MIAMI BEACH FL

Principal Office Address  
16401 N.W. 2ND AVE.  
SUITE 204  
NORTH MIAMI BEACH FL

3. Date Formed or Registered  
**04/21/1981**

5a. Capital Contributions as Shown on record  
**\$16,000.00**

3a. Date of Last Report  
**01/11/1996**

5b. Amount of Capital Contributions in FLORIDA to date  
**\$16,000**

4. State or Country of Formation  
**FL**

2. Mailing Address

2a. Principal Office Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

6. FEI Number  
**59-2091641**

Applied For  
 Not Applicable

City & State

City & State

7. Certificate of Status Desired

\$8.75 Additional Fee Required

Zip Country

Zip Country

8. Make check payable to: Dept. of State (See reverse side for fee information)

9. Name and Address of Current Registered Agent

**ROSEN, BORIS  
25 SE 2ND AVE.  
SUITE 220  
MIAMI FL 33131**

10. If changed, new Registered Agent/Office

Name

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

Suite, Apt. #, etc.

City

**FL**

Zip Code

10a. Pursuant to the provisions of sections 620.1051 and 620.192, Florida Statutes, the above named limited partnership organized or registered under the laws of the State of Florida, 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 its general partner(s). I hereby accept the appointment of registered agent. I am familiar with, and accept the obligations of section 620.192, Florida Statutes.

SIGNATURE (Registered Agent Accepting Appointment)

DATE

**A GENERAL PARTNER THAT IS A CORPORATION, LIMITED PARTNERSHIP OR OTHER BUSINESS ENTITY MUST BE REGISTERED AND ACTIVE WITH THIS OFFICE.**

11. Name(s) of General Partner(s)

11a. Address of Each General Partner (Do NOT Use Post Office Box Numbers)

11b. City, State & Zip Code

11c. Registration/Document Number

**GOLD COAST SURG.MED.ASSC**

**16401 N.W. 2ND AVE.#204**

**N. MIAMI BEACH FL**

**F25557**

**400001974414--9  
-10/15/96--01150--012  
\*\*\*\*\*250.75 \*\*\*\*\*250.75**

**Note: General partners MAY NOT be changed on this form; an amendment must be filed to change a general partner.**

12. 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 release the Division of Corporations from any liability of non-compliance with Section 119.07(3)(k) in the event that the information supplied is deemed exempt from public access. I further certify that the information indicated on this annual report is true and accurate and that my signature shall have the same legal effects as if made under oath. I further certify that I am a General Partner of the limited partnership, receiver or trustee empowered to execute this report as required by chapter 620, Florida Statutes.

SIGNATURE BY: *[Signature]*

, President

DATE *10/30/96*

Typed or Printed Name of General Partner Signing Form

**GOLD COAST SURGICAL MEDICAL ASSOC, INC**

Telephone Number **(305)947-0943**

CR2E003 (6/96)