


**FILE ON OR BEFORE APRIL 8, 1998 TO AVOID
REVOCATION AND \$500 PENALTY FEE**

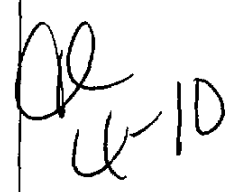
LIMITED PARTNERSHIP ANNUAL REPORT 1998		 FLORIDA DEPARTMENT OF STATE Sandra B. Mortham Secretary of State DIVISION OF CORPORATIONS		FILED SECRETARY OF STATE DIVISION OF CORPORATIONS 98 APR -8 AM 11:45	
1. Name of Limited Partnership MEDICAL PRIMARY CARE AND DIAGNOSTIC CENTERS, LTD		1a. DOCUMENT # A23275			
Mailing Address 5978 POWERS AVENUE JACKSONVILLE FL 32217		Principal Office Address 5978 POWERS AVENUE JACKSONVILLE FL 32217		3. Date Formed or Registered 09/22/1986 3a. Date of Last Report 12/23/1996 4. State or Country of Formation FL	
2. Mailing Address Suite, Apt. #, etc. City & State Zip Country		2a. Principal Office Address Suite, Apt. #, etc. City & State Zip Country		5a. Capital Contributions as Shown on record. \$100.00 5b. Amount of Capital Contributions in FLORIDA to date: 100.00	
6. FEI Number 59-2692388		<input type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable			
7. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required			
8. Make check payable to: Dept. of State (See reverse side for fee information)					

9. Name and Address of Current Registered Agent JEREMIAH, CLIFFORD J. 5978 POWERS AVENUE JACKSONVILLE FL 32217	10. If changed, new Registered Agent/Office Name _____ Street Address (P.O. Box Number is Not Acceptable) _____ Suite, Apt. #, etc. 200002488162-3 City -04/14/98--01057--011 ***141.25 FL ***141.25
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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) MEDICAL PRIMARY CARE AND DIA	11a. Address of Each General Partner (Do NOT Use Post Office Box Numbers) 5978 POWERS AVE.	11b. City, State & Zip Code JACKSONVILLE FL	11c. Registration/Document Number H95827 
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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  DATE **4/9/98**

Typed or Printed Name of General Partner Signing Form _____

Daytime Telephone Number _____

CR2E003 (12/97)