


**2004 LIMITED PARTNERSHIP ANNUAL REPORT (AR)**  
**DUE BY MAY 1, 2004**

**FILED**  
**Apr 30, 2004 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # A33208</b>			
1. Entity Name <b>FLORIDA MEDICAL SUPPLY OF BREVARD COUNTY, LTD.</b>			
Principal Place of Business <b>260 POINCIANA DRIVE INDIAN HARBOUR BEACH FL 32937</b>		Mailing Address <b>260 POINCIANA DRIVE INDIAN HARBOUR BEACH FL 32937</b>	
2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc		Suite, Apt. # etc	
City & State		City & State	
Zip	Country	Zip	Country
5. Name and Address of Current Registered Agent <b>WEARE, J L 260 POINCIANA DRIVE INDIAN HARBOR BEACH FL 32937</b>		7. Name and Address of New Registered Agent Name Street Address (P O Box Number is Not Acceptable) City <b>FL</b> 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 _____ <small>Signature typed or printed name of registered agent and title if applicable</small>			
9. Capital Contributions as Shown on record. <b>\$2,000.00</b>		10. Amount of Capital Contributions in FLORIDA to date.	
11. MAKE CHECK PAYABLE TO FL. DEPT. OF STATE SEE REVERSE SIDE FOR FEE INFORMATION			
<b>A GENERAL PARTNER THAT IS A BUSINESS ENTITY MUST BE REGISTERED AND ACTIVE WITH THIS OFFICE.</b> <b>NOTE: General Partners MAY NOT be changed on the form; an amendment must be filed to change a general partner.</b>			
12. GENERAL PARTNER INFORMATION		13. ADDRESS CHANGES ONLY	
DOCUMENT #	<b>S79094</b>	STREET ADDRESS	
NAME	<b>FLORIDA MEDICAL SUPPLY OF BREVARD COUNTY,</b>	CITY - ST - ZIP	
STREET ADDRESS	<b>260 POINCIANA DRIVE</b>		
CITY - ST - ZIP	<b>INDIAN HARBOR BCH FL</b>		
DOCUMENT #		STREET ADDRESS	
NAME		CITY - ST - ZIP	
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STREET ADDRESS			
CITY - ST - ZIP			



MOORE CR2E003 (11/03)

4. FEI Number **59-3088014** Applied For  
Not Applicable

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

14. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a General Partner of the limited partnership or the receiver or trustee empowered to execute this report as required by Chapter 620, Florida Statutes

**SIGNATURE:**  **J.L. WEARE, PRESIDENT**  
**FLORIDA MEDICAL SUPPLY OF**  
**BREVARD COUNTY, INC.**

**APRIL 22, 2004** **321-777-0166**  
Date Daytime Phone #

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING GENERAL PARTNER

STAPLE CHECK HERE