


**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 04, 2004 08:00 AM
Secretary of State

DOCUMENT # F26561 1. Entity Name LAWTON DENTAL LABORATORY, INC.	
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Principal Place of Business % THOMAS C LAWTON, D.M.D. 201 N LAKEMONT AVENUE WINTER PARK, FL 32792-3211	Mailing Address % THOMAS C LAWTON, D.M.D. 201 N LAKEMONT AVENUE WINTER PARK, FL 32792-3211
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DO NOT WRITE IN THIS SPACE



01292004 No Chg-P CR2E034 (10/03)

4. FEI Number 59-3080896	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent LAWTON, THOMAS C., DMD 201 N LAKEMONT AVENUE WINTER PARK, FL

**DO NOT WRITE
IN THIS SPACE**

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 (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS \$150.00 After May 1, 2004 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	1000000033846 02/05/04-80060-007 150.00
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	DP LAWTON, THOMAS C, DMD 201 N LAKEMONT AVE WINTER PARK, FL 00000,
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12. 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 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 607, 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: Thomas C. Lawton DMD 2/2/04 (407) 644-8248
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #