

# 2005 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

**FILED**  
**Mar 07, 2005 08:00 AM**  
**Secretary of State**

**DOCUMENT # F95281**

1. Entity Name

MIAMI UROLOGICAL ASSOCIATES, INC.



Principal Place of Business

747 PONCE DE LEON BLVD  
 SUITE 700  
 CORAL GABLES FL 33134

Mailing Address

747 PONCE DE LEON BLVD  
 SUITE 700  
 CORAL GABLES FL 33134

2. Principal Place of Business

3. Mailing Address

Suite, Apt #, etc.

Suite, Apt #, etc.

City & State

City & State

Zip

Country

Zip

Country



1st MOORE

CR2E034 (10/04)

4. FEI Number

59-2206158

Applied For

Not Applicable

5. Certificate of Status Desired

**\$8.75** Additional  
 Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

WASMER, JOSE M., M.D.  
 747 PONCE DE LEON BLVD.  
 STE 700  
 CORAL GABLES FL 33134

Name

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

City

**FL**

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

Signature typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00**

**After May 7, 2005 Fee Will Be \$550.00**

**Make Check Payable to Florida Department of State**

9. Election Campaign Financing  
 Trust Fund Contribution

**\$5.00** May Be  
 Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

| TITLE | NAME              | STREET ADDRESS         | CITY - ST - ZIP | <input type="checkbox"/> Delete |
|-------|-------------------|------------------------|-----------------|---------------------------------|
| PD    | WASMER, JOSE M MD | 747 PONCE DE LEON #700 | CORAL GABLES FL | <input type="checkbox"/>        |
| ST    | MAGGIOLO, LUIS F. | 747 PONCE DE LEON #700 | CORAL GABLES FL | <input type="checkbox"/>        |
|       |                   |                        |                 | <input type="checkbox"/> Delete |
|       |                   |                        |                 | <input type="checkbox"/> Delete |
|       |                   |                        |                 | <input type="checkbox"/> Delete |
|       |                   |                        |                 | <input type="checkbox"/> Delete |

| TITLE | NAME | STREET ADDRESS | CITY - ST - ZIP | <input type="checkbox"/> Change | <input type="checkbox"/> Addition |
|-------|------|----------------|-----------------|---------------------------------|-----------------------------------|
|       |      |                |                 | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |                 | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |                 | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |                 | <input type="checkbox"/>        | <input type="checkbox"/>          |

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 03/07/05-20020-018 150.00

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

*J. Wasmer* MD

1/24/05 (203) 444-2858

Date Daytime Phone #