

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

CORPORATION
ANNUAL REPORT
1995



FLORIDA DEPARTMENT OF STATE
Gandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

95 APR -4 PM 7: 15

DOCUMENT # **G26430** (0)

1. Corporation Name
AMBULATORY ANESTHESIA ASSOCIATES, P.A.

Principal Place of Business Mailing Address
% EILEEN G. LEVIN, M.D.
509 RIVERSIDE DR.
STUART FL 34994
US

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified **03/03/1983** 3a. Date of Last Report **01/31/1994**
4. FEI Number **59-2296654** Applied For
Not Applicable
5. Certificate of Status Desired **\$8.75 Additional Fee Required**
6. Election Campaign Financing Trust Fund Contribution **\$5.00 May Be Added to Fees**
8. This corporation has liability for intangible tax under S. 199.032, Florida Statutes Yes No

2. Principal Place of Business 2a. Mailing Address
21 Suite, Apt. #, etc. 26 Suite, Apt. #, etc.
22 City & State 27 City & State
23 Zip 24 **34995** 25 Country 29 **34995** 30 Country

9. Name and Address of Current Registered Agent
LEVIN, EILEEN G., M.D.
509 RIVERSIDE DR #100
STUART FL 34994

10. Name and Address of New Registered Agent
81 Name
82 Street Address (P.O. Box Number is Not Acceptable)
83
84 City **FL** 85 Zip Code **34995**

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation 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 the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when re-registering)

12. OFFICERS AND DIRECTORS

TITLE	DP
NAME	LEVIN, EILEEN G
STREET ADDRESS	509 RIVERSIDE DR #100
CITY - ST - ZIP	STUART, FL 34994
TITLE	VP
NAME	VENABLE, HENRY D.
STREET ADDRESS	509 RIVERSIDE DR #100
CITY - ST - ZIP	STUART, FL 34994
TITLE	ST
NAME	ALLEN, BYLSMA S
STREET ADDRESS	509 RIVERSIDE DR., #100
CITY - ST - ZIP	STURAT FL 34994
TITLE	
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY - ST - ZIP	

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
1.2 NAME	
1.3 STREET ADDRESS	
1.4 CITY - ST - ZIP	34995
2.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
2.2 NAME	
2.3 STREET ADDRESS	PO Box 446
2.4 CITY - ST - ZIP	STUART FL 34995
3.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
3.2 NAME	
3.3 STREET ADDRESS	1565 SW Saint Andrews
3.4 CITY - ST - ZIP	Jalm City FL 34990
4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
4.2 NAME	
4.3 STREET ADDRESS	
4.4 CITY - ST - ZIP	
5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
5.2 NAME	
5.3 STREET ADDRESS	
5.4 CITY - ST - ZIP	
6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
6.2 NAME	
6.3 STREET ADDRESS	
6.4 CITY - ST - ZIP	

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 110.07(3)(b), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 007, Florida Statutes, and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: Henry D. Venable **HENRY D. VENABLE** 3/30/95 407 287 9955
Signature and typed or printed name of signing officer or director