

2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jul 13, 2004 08:00 AM
Secretary of State

DOCUMENT # H14689

1. Entity Name
DOUGLAS C. HALL, M.D., P.A.



Principal Place of Business

2600 SE 17TH ST
OCALA, FL 34771 US

Mailing Address

2600 SE 17TH ST
OCALA, FL 34771 US



07012004 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number
59-2526198

Applied For
Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

HALL, DOUGLAS C.
1504 SE 25 TERRACE
OCALA, FL 34471

**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)

DATE

FILE NOW!!! FEE IS \$150.00
Due by September 8, 2004

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.

10. OFFICERS AND DIRECTORS

TITLE	P
NAME	HALL, DOUGLAS C.
STREET ADDRESS	1504 SE 25 TERRACE
CITY-ST-ZIP	OCALA, FL 34471

TITLE	
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STREET ADDRESS	
CITY-ST-ZIP	

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07/13/04-80001-007 150.00

**DO NOT WRITE
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 19.07(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: Douglas C Hall MD

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #