

**2005 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**May 04, 2005 08:00 AM**  
**Secretary of State**

**DOCUMENT # H24270**

1. Entity Name  
**INTERNAL MEDICINE ASSOCIATES OF ST. JOHNS  
COUNTY, P.A.**



Principal Place of Business

**16 ST. JOHNS MEDICAL PARK DRIVE  
ST. AUGUSTINE, FL 32086-5299 US**

Mailing Address

**16 ST. JOHNS MEDICAL PARK DRIVE  
ST. AUGUSTINE, FL 32086-5299 US**



04202005 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number  
**59-2449088**

Applied For

Not Applicable

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

6. Name and Address of Current Registered Agent

**ROZAS, JOSEPH R., M.D.  
16 ST JOHNS MEDICAL PARK DR  
ST. AUGUSTINE, FL 32086**

**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  
After May 1, 2005 Fee will be \$550.00**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

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

10. OFFICERS AND DIRECTORS

TITLE	P
NAME	ROZAS, JOSEPH R., MD
STREET ADDRESS	16 ST JOHNS MEDICAL PARK DR
CITY-ST-ZIP	SAINT AUGUSTINE, FL 32086
TITLE	ST
NAME	CARAMES, ERNEST J
STREET ADDRESS	16 ST. JOHNS MEDICAL PARK DRIVE
CITY-ST-ZIP	ST. AUGUSTINE, FL 320865299
TITLE	D
NAME	FRADY, WALTER B
STREET ADDRESS	16 ST JOHNS MEDICAL PARK DR
CITY-ST-ZIP	SAINT AUGUSTINE, FL 32086
TITLE	D
NAME	DELAMERENS, GOAR
STREET ADDRESS	16 ST JOHNS MEDICAL PARK DR
CITY-ST-ZIP	SAINT AUGUSTINE, FL 32086
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

U00000362498  
05/05/05-80120-006 150.00

**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 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

Date

Daytime Phone #