2006 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # H40911

1. Entity Name
WESTGATE MEDICAL CENTER, INC.

Principal Place of Business	Mailing Address
15814 WEST STATE ROAD 84 SUNRISE, FL 33326	15814 WEST STATE ROAD 84 SUNRISE, FL 33326

DO NOT WRITE IN THIS SPACE

01242006   No Chg-P   CR2E034 (11/05)

4. FEI Number
59-2498602

☐ Applied For
☐ Not Applicable

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

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6. Name and Address of Current Registered Agent

SANDLER, MYRON
4020 SHERIDAN ST., STE C
HOLLYWOOD, FL 33021

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, 2006 Fee will be $550.00

9. Election Campaign Financing Trust Fund Contribution. ☐   **$5.00** May Be Added to Fees

U000000495196
04/20/06-80075-018 150.00

10.   OFFICERS AND DIRECTORS

TITLE	PD
NAME	PEARLMUTTER, NINA J.
STREET ADDRESS	15814 W.STATE RD.84
CITY-ST-ZIP	SUNRISE, FL

TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

TITLE	
NAME	
STREET ADDRESS	
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TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

DO NOT WRITE IN THIS SPACE

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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 the empowered

SIGNATURE: _Nina J Pearlmutter MD_   4/1/06   (954)384-72

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR   Date   Daytime Phone #