


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 28, 2008 08:00 AM
Secretary of State

DOCUMENT # H60502		
1. Entity Name HALLMARK MEDICAL CENTER, INC.		
Principal Place of Business 2500 EAST HALLANDALE BEACH BLVD. #P-Q HALLANDALE, FL 33009 US	Mailing Address 2500 EAST HALLANDALE BEACH BLVD #P-Q HALLANDALE, FL 33009 US	



01172008 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-1696104	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input checked="" type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent ROTH, LEON MD 2500 E HALLANDALE BEACH BLVD #PQ HALLANDALE, FL 33008	DO NOT WRITE IN THIS SPACE
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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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____
Signature typed or printed name of registered agent and title if applicable.

FILE NOW!!! FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PS ROTH, LEON, MD 2500 E HALLANDALE BEACH BLVD HALLANDALE, FL 33009
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01/31/08-80019-012 158.75

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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 like empowered.

SIGNATURE: (x)  **Leon Roth, MD (x)** **1/24/08** **(954) 455-2385**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #