


**2004 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Feb 19, 2004 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # H93545</b> 1. Entity Name KERRY EDWIN ROBSON, D.D.S., P.A.	
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Principal Place of Business 3820 TAMPA ROAD SUITE 201 PALM HARBOR, FL 34684	Mailing Address 3820 TAMPA ROAD SUITE 201 PALM HARBOR, FL 34684
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**DO NOT WRITE IN THIS SPACE**



02112004 No Chg-P CR2E034 (10/03)

4. FEI Number 59-2674705	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent  ROBSON, KERRY 5035 CROSS POINTE DRIVE OLDSMAR, FL 34677
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**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.

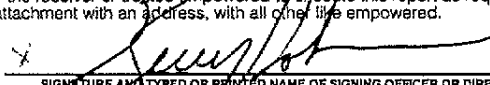
SIGNATURE \_\_\_\_\_ (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

<b>FILE NOW!!! FEE IS \$150.00</b> <b>After May 1, 2004 Fee will be \$550.00</b>	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be</b> <b>Added to Fees</b>	U00000058311 02/20/04-80024-016 150.00
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PDS ROBSON, KERRY EDWIN 5035 CROSS POINTE DRIVE OLDSMAR, FL
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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 title empowered.

**SIGNATURE:**   
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR  
KERRY EDWIN ROBSON, D.D.S.

Date

Daytime Phone #