

FILE NOW: FILING FEE AFTER MAY 1 IS \$550.00

FILED

Mar 13 1997 8:00am
Secretary of State

PROFIT
CORPORATION
ANNUAL REPORT
1997



FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # J29554 (9)

1. Corporation Name
PAULINE CHUSID, M.D., P.A.



Principal Place of Business

24 FALCONWOOD COURT
FT MYERS FL 33919
US

Mailing Address

24 FALCONWOOD COURT
FT MYERS FL 33919-7535
US

2. Principal Place of Business

21 State, Apt. #, etc.

22 City & State

23 Zip Country

24 25

2a. Mailing Address

26 State, Apt. #, etc.

27 City & State

28 Zip Country

29 30

3. Date Incorporated or Qualified

08/18/1986

3a. Date of Last Report

05/01/1996

4. FEI Number

59-2700536

Applied For

Not Applicable

5. Certificate of Status Desired

☐ \$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution

☐ \$5.00 May Be
Added to Fees

8. This corporation has liability for intangible tax under s. 199.032,
Florida Statutes

☐ Yes ☐ No

9. Name and Address of Current Registered Agent

CHUSID, PAULINE
24 FALCONWOOD CT
FT. MYERS FL 33912

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

(Print name of the person whose signature is required and how it applies)

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

| | | |
|----------------|------------------|---------------------------------|
| TITLE | DP | <input type="checkbox"/> DELETE |
| NAME | CHUSID, PAULINE | |
| STREET ADDRESS | 24 FALCONWOOD CT | |
| CITY-STATE-ZIP | FT MYERS FL | |
| TITLE | | <input type="checkbox"/> DELETE |
| NAME | | |
| STREET ADDRESS | | |
| CITY-STATE-ZIP | | |
| TITLE | | <input type="checkbox"/> DELETE |
| NAME | | |
| STREET ADDRESS | | |
| CITY-STATE-ZIP | | |
| TITLE | | <input type="checkbox"/> DELETE |
| NAME | | |
| STREET ADDRESS | | |
| CITY-STATE-ZIP | | |
| TITLE | | <input type="checkbox"/> DELETE |
| NAME | | |
| STREET ADDRESS | | |
| CITY-STATE-ZIP | | |

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

| | |
|--------------------|---|
| 1.1 TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| 1.2 NAME | |
| 1.3 STREET ADDRESS | |
| 1.4 CITY-STATE-ZIP | |
| 2.1 TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| 2.2 NAME | |
| 2.3 STREET ADDRESS | |
| 2.4 CITY-STATE-ZIP | |
| 3.1 TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| 3.2 NAME | |
| 3.3 STREET ADDRESS | |
| 3.4 CITY-STATE-ZIP | |
| 4.1 TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| 4.2 NAME | |
| 4.3 STREET ADDRESS | |
| 4.4 CITY-STATE-ZIP | |
| 5.1 TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| 5.2 NAME | |
| 5.3 STREET ADDRESS | |
| 5.4 CITY-STATE-ZIP | |
| 6.1 TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| 6.2 NAME | |
| 6.3 STREET ADDRESS | |
| 6.4 CITY-STATE-ZIP | |

14. I do 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 included on this annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Pauline Chusid, M.D.

2/7/97

Daytime Phone #

CR2E034 (9/96)