


**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 17, 2004 08:00 AM
Secretary of State

DOCUMENT # J30868 1. Entity Name PAUL E. SIMON, M.D., P.A.	
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Principal Place of Business 1250 E. HALLANDALE BLVD. SUITE 800 HALLANDALE, FL 33009	Mailing Address 1250 E. HALLANDALE BLVD. SUITE 800 HALLANDALE, FL 33009
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DO NOT WRITE IN THIS SPACE



02052004 No Chg-P CR2E034 (10/03)

4. FEI Number 59-2713174	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 SIMON, PAUL E. 1250 E. HALLANDALE BLVD. SUITE 800 HALLANDALE, FL 33009	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 _____ <small>Signature, typed or printed name of registered agent and title if applicable</small>	(NOTE: Registered Agent signature required when reinstating)	DATE _____
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FILE NOW!!! FEE IS \$150.00 After May 1, 2004 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	000000090246 03/17/04-80011-009 150.00
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PD SIMON, PAUL E. 1250 E. HALLANDALE BLVD. HALLANDALE, 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 19.07(3)(f), 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: <u>Paul Simon M.D. - PAUL SIMON</u> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>	<u>3/15/04</u> <small>Date</small>	<u>954-451-5050</u> <small>Day/Time Phone #</small>
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