

**2008 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 10, 2008 08:00 A
Secretary of State

DOCUMENT # J61806

1. Entity Name
INTERNATIONAL ANESTHESIOLOGY ASSOCIATES, INC.



Principal Place of Business
1100 NW 95TH ST
2ND FLOOR
MIAMI, FL 33150-2038

Mailing Address
POST OFFICE BOX 530759
MIAMI, FL 33153



02112008 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
59-2816117

Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

LAMBERT, LYNDALL
701 BRICKELL AVENUE
SUITE 3000
MIAMI, FL 33131

**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]

Signature, typed or printed name of registered agent and title, if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

2/22/08

**FILE NOW!!! FEE IS \$150.00
After May 1, 2008 Fee will be \$550.00**

9. Election Campaign Financing
Trust Fund Contribution. ☐

**\$5.00 May Be
Added to Fees**

U000000852709
03/26/08-80039-024 150.00

10. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
P
SCHOU, MICHAEL, MD
4245 LAKE ROAD
MIAMI, FL 33137

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
VP
VENDRYES, CHRIS MD
14422 SW 92 COURT
MIAMI, FL 33176

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

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 like information.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

[Signature]
Michael J Schou, MD, Pain Management
1100 NW 95 Str. 2nd floor Pain Center
Miami, Florida 33150-2038
Phone: 305 694 3775, Fax 305 694 3678
E mail: micschou@aol.com

Daytime Phone