

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

CORPORATION
ANNUAL REPORT
1995



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

APPROVED
AND
FILED

SEMI 11 AM 1:45

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **K26071** (6)

1. Corporation Name

DIGESTIVE DISEASE CONSULTANTS, P.A.

Principal Place of Business

661 E ALTAMONTE DR
SUITE 321
ALTAMONTE SPRINGS FL 32701

Mailing Address

661 E ALTAMONTE DR
SUITE 321
ALTAMONTE SPRINGS FL 32701

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified 06/09/1988	3a. Date of Last Report 02/09/1994
4. FID Number 59-2894914	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
6. Election Campaign Financing Fund Contribution <input type="checkbox"/>	\$5.00 May Be Added to Fees
7. This corporation has liability for subscription fees under 22-1201 F.S. Florida Statutes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	

2. Principal Place of Business	2a. Mailing Address
21. State and Zip	26. State and Zip
22. City & State	27. City & State
23. City & State	28. City & State
24. City & State	29. City & State
25. City & State	30. City & State

9. Name and Address of Current Registered Agent	10. Name and Address of New Registered Agent
LEBIODA, DAVID H. MD 4024 W DANBY CT WINTER SPRINGS FL 32708	81. Name
	82. Street Address, P.O. Box Number, H.F. A. or Apt. No.
	83. City & State
	84. City, State, Zip Code

11. The undersigned, the president of the corporation, hereby certifies that the above named corporation conforms to the information on this report for the purpose of complying with the provisions of the Florida Statutes, Chapter 220, and that the undersigned is duly authorized to file this report and to accept the appointment of the registered agent.

Signature of President: _____ Date: _____

12. REGISTERED AGENTS	13. ADDITIONAL EXCHANGED, TRANSFERRED, AND DELETED AGENTS
NAME: D LEBIODA, DAVID H. MD 4024 W DANBY COURT WINTER SPRINGS FL	NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____
NAME: D STRAKER, RICHARD J. MD 721 GLEN EAGLE DR WINTER SPRINGS FL	NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____
NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____	NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____
NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____	NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____
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NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____	NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____
NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____	NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____

14. The undersigned certifies that the information supplied with this filing is voluntarily furnished and claims not qualify for the exemption stated in Section 220.02(1)(b), Florida Statutes. I further certify that the information included on this annual report is supplemental information not required by law and is complete and that my signature shall make the same legal effect as if made under oath. That I am an officer or director of this corporation or the reason of my position authorized to execute this report as required by Chapter 220, Florida Statutes, and that my name appears on Block 12 or 13 of this report as an attached with an address.

SIGNATURE: *David L. Lebioda*
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4/2/95
407 830 866/