


**2005 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED

**Feb 26, 2005 08:00 AM
Secretary of State**

DOCUMENT # K28850 1. Entity Name GULF COAST EMERGENCY PHYSICIANS, P.A.	
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Principal Place of Business C/O TAX SAVERS 812 TAMiami TRAIL, SUITE 1 PORT CHARLOTTE, FL 33953 US	Mailing Address PO BOX 380848 PORT CHARLOTTE, FL 33948 US
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02012005 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number 65-0075127	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 OAKS, DAVID K 252 W. MARION AVE. PUNTA GORDA, FL 33950	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 _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D WILLIAMS, SAMUEL 812 TAMiami TRAIL, SUITE 1 PORT CHARLOTTE, FL 33953
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D MOZZETTI, MICHAEL 812 TAMIAM TRAIL, SUITE 1 PORT CHARLOTTE, FL 33953
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D JAMES, RAYMOND 812 TAMiami TRIAL, SUITE 1 PORT CHARLOTTE, FL 33953
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D JAVIER ARISTIMUNO, IUAQUIN 812 TAMiami TRAIL, SUITE 1 PORT CHARLOTTE, FL 33953
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	

100000244070
02/26/05-80005-024 150.00

**DO NOT WRITE
IN THIS SPACE**

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 like empowered.

SIGNATURE: *Samuel Williams MD* *Samuel Williams* *2/24/05* *941-624-0207*
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #