

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

FILED
Feb 17, 1999 8:00am
Secretary of State

PROFIT CORPORATION
ANNUAL REPORT
1999



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

02-17-1999 90031 001 ***158.75

DOCUMENT # K56591

1. Corporation Name
TAMPA NEUROLOGY ASSOCIATES, P.A.



DO NOT WRITE IN THIS SPACE

Principal Place of Business
2919 SWANN AVE. STE 401
TAMPA FL 33609

Mailing Address
2919 SWANN AVE. STE 401
TAMPA FL 33609

3. Date Incorporated or Qualified
01/06/1989

4. FEI Number
59-2919747

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 owes the current year Intangible Personal Property Tax. Yes No

2. Principal Place of Business
21 Suite, Apt. #, etc.
22 City & State
23 Zip Country
24 25

2a. Mailing Address
26 Suite, Apt. #, etc.
27 City & State
28 Zip Country
29 30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

RUGG, JOSEPH
201 N FRANKLIN ST
SUITE 2100
TAMPA FL 33602

81 Name
82 Street Address (P.O. Box Number is Not Acceptable)
83
84 City
85 Zip Code
FL

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 _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	<input type="checkbox"/> DELETE	1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	DERGAY, STEPHEN M., M.D.	1.2 NAME	
STREET ADDRESS	2919 SWANN AVE #401	1.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL	1.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	DVS	2.2 NAME	
STREET ADDRESS	STEEN, SUSAN J., M.D.	2.3 STREET ADDRESS	
CITY-ST-ZIP	2919 SWANN AVE #401	2.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	PAS	3.2 NAME	
STREET ADDRESS	DERGAY, STEPHEN M., M.D.	3.3 STREET ADDRESS	
CITY-ST-ZIP	2919 SWANN AVE #401	3.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		4.2 NAME	
STREET ADDRESS		4.3 STREET ADDRESS	
CITY-ST-ZIP		4.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		5.2 NAME	
STREET ADDRESS		5.3 STREET ADDRESS	
CITY-ST-ZIP		5.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		6.2 NAME	
STREET ADDRESS		6.3 STREET ADDRESS	
CITY-ST-ZIP		6.4 CITY-ST-ZIP	

14. 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 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 with all other like empowered.

SIGNATURE: _____ DATE: 1/26/99 DAYTIME PHONE #: 813-872-1548
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

CR2E034 (11/98)