

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

CORPORATION  
ANNUAL REPORT  
1995



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

APPROVED  
AND  
FILED

95 APR 19 PH 4:34

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # K85763 (6)  
1. Corporation Name  
NEUROLOGY ASSOCIATES OF THE TREASURE COAST, P.A.

Principal Place of Business  
509 RIVERSIDE DRIVE, SUITE 305  
STUART FL 34994

Mailing Address  
509 RIVERSIDE DRIVE, SUITE 305  
STUART FL 34994

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified 05/05/1989 3a. Date of Last Report 05/01/1994  
4. FEI Number 65-0120879 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 has liability for intangible tax under S. 199.032, Florida Statutes ☐ Yes ☐ No

2. Principal Place of Business 2a. Mailing Address  
21 901 SE MONTEREY COMMONS Suite, Apt. #, etc. SAME AS 2  
22 City & State 27 City & State  
23 STUART, FL 28  
24 34996 25 MARTIN 29 30 Country

TOBIAS, HAL  
509 RIVERSIDE DR. STE 305  
STUART FL 34994

10. Name and Address of New Registered Agent  
81 Name  
82 Street Address (P.O. Box Number is Not Acceptable)  
83 901 SE MONTEREY COMMONS BLVD  
84 STUART FL 85 34996

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

Signature of person named as registered agent and the if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

TITLE D  
NAME TOBIAS, HAL M. M.D.  
STREET ADDRESS 509 RIVERSIDE DRIVE  
CITY-ST-ZIP STUART FL

1.1 TITLE ☒ Change ☐ Addition  
1.2 NAME  
1.3 STREET ADDRESS 901 SE MONTEREY COMMONS BLVD  
1.4 CITY-ST-ZIP STUART FL 34996  
2.1 TITLE ☐ Change ☐ Addition  
2.2 NAME  
2.3 STREET ADDRESS  
2.4 CITY-ST-ZIP  
3.1 TITLE ☐ Change ☐ Addition  
3.2 NAME  
3.3 STREET ADDRESS  
3.4 CITY-ST-ZIP  
4.1 TITLE ☐ Change ☐ Addition  
4.2 NAME  
4.3 STREET ADDRESS  
4.4 CITY-ST-ZIP  
5.1 TITLE ☐ Change ☐ Addition  
5.2 NAME  
5.3 STREET ADDRESS  
5.4 CITY-ST-ZIP  
6.1 TITLE ☐ Change ☐ Addition  
6.2 NAME  
6.3 STREET ADDRESS  
6.4 CITY-ST-ZIP

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), 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 in an attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

(Anyline Please)