

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

PROFIT
CORPORATION
ANNUAL REPORT
1996



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

DOCUMENT # **K95697** (4)

1. Corporation Name

WEST FLORIDA ANESTHESIA, P.A.



Principal Place of Business

Mailing Address

**WEST FLORIDA ANESTHESIA, P.A.
11377 CORTEZ BLVD.
BROOKSVILLE FL 34613**

**WEST FLORIDA ANESTHESIA, P.A.
P.O. BOX 5719
SPRING HILL FL 34606**

3. Date Incorporated or Qualified

06/15/1989

3a. Date of Last Report

05/01/1995

2. Principal Place of Business

2a. Mailing Address

4. FEI Number

59-2950096

Applied For

Not Applicable

21

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. Certificate of Status Desired

☐

**\$8.75 Additional
Fee Required**

22

City & State

City & State

6. Election Campaign Financing
Trust Fund Contribution

☐

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

23

Zip

Country

Zip

Country

8. This corporation has liability for intangible tax under s. 199.032,
Florida Statutes ☒ Yes ☐ No

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

**TRACY, DEBORAH MD
10019 TWELVE OAKS CT
BROOKSVILLE FL 34613**

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

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, typed or printed name of registered agent and title, 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** ☐ DELETE

NAME **TRACY, DEBORAH MD**
STREET ADDRESS **10019 TWELVE OAKS CT**
CITY-ST-ZIP **BROOKSVILLE FL**

TITLE **VT** ☐ DELETE

NAME **SANFILIPPO, ANGELO D. MD**
STREET ADDRESS **12306 EVERARD DR.**
CITY-ST-ZIP **SPRING HILL FL 34609**

TITLE ☐ DELETE

NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ DELETE

NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ DELETE

NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ DELETE

NAME
STREET ADDRESS
CITY-ST-ZIP

1.1 TITLE

1.2 NAME

1.3 STREET ADDRESS

1.4 CITY-ST-ZIP

2.1 TITLE

2.2 NAME

2.3 STREET ADDRESS

2.4 CITY-ST-ZIP

3.1 TITLE

3.2 NAME

3.3 STREET ADDRESS

3.4 CITY-ST-ZIP

4.1 TITLE

4.2 NAME

4.3 STREET ADDRESS

4.4 CITY-ST-ZIP

5.1 TITLE

5.2 NAME

5.3 STREET ADDRESS

5.4 CITY-ST-ZIP

6.1 TITLE

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 on an attachment with an address.

SIGNATURE: ✓

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

3/11/96 352-597-3060
Daytime Phone

CR2E034 (12/95)