

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

FILED

Apr 22 1997 8:00am
Secretary of State

PROFIT CORPORATION ANNUAL REPORT 1997		FLORIDA DEPARTMENT OF STATE Sandra B. Mortham Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # **K95697** (4)
1. Corporation Name
WEST FLORIDA ANESTHESIA, P.A.

Principal Place of Business WEST FLORIDA ANESTHESIA, P.A. 11377 CORTEZ BLVD. BROOKSVILLE FL 34613	Mailing Address WEST FLORIDA ANESTHESIA, P.A. P.O. BOX 5719 SPRING HILL FL 34611-0719
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2. Principal Place of Business		2a. Mailing Address		3. Date Incorporated or Qualified 06/15/1989	3a. Date of Last Report 03/15/1996
21	Suite, Apt. #, etc.	26	Suite, Apt. #, etc.	4. FEI Number 59-2950096	Applied For Not Applicable
22	City & State	27	City & State	5. Certificate of Status Desired ☐	\$8.75 Additional Fee Required
23	Zip	28	Zip	6. Election Campaign Financing Trust Fund Contribution ☐	\$5.00 May Be Added to Fees
24	Country	29	Country	8. This corporation has liability for intangible tax under s. 199.032, Florida Statutes ☒ Yes ☐ No	

9. Name and Address of Current Registered Agent TRACY, DEBORAH MD 10019 TWELVE OAKS CT BROOKSVILLE FL 34613		10. Name and Address of New Registered Agent	
		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

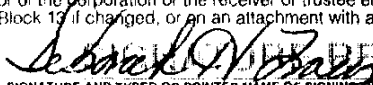
(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	D ☐ DELETE	1.1 TITLE	☐ Change ☐ Addition
NAME	TRACY, DEBORAH MD	1.2 NAME	
STREET ADDRESS	10019 TWELVE OAKS CT	1.3 STREET ADDRESS	
CITY-ST-ZIP	BROOKSVILLE FL	1.4 CITY-ST-ZIP	
TITLE	VT ☐ DELETE	2.1 TITLE	☐ Change ☐ Addition
NAME	SANFILIPPO, ANGELO D. MD	2.2 NAME	
STREET ADDRESS	12306 EVERARD DR.	2.3 STREET ADDRESS	
CITY-ST-ZIP	SPRING HILL FL 34609	2.4 CITY-ST-ZIP	
TITLE	☐ DELETE	3.1 TITLE	☐ Change ☐ Addition
NAME		3.2 NAME	
STREET ADDRESS		3.3 STREET ADDRESS	
CITY-ST-ZIP		3.4 CITY-ST-ZIP	
TITLE	☐ DELETE	4.1 TITLE	☐ Change ☐ Addition
NAME		4.2 NAME	
STREET ADDRESS		4.3 STREET ADDRESS	
CITY-ST-ZIP		4.4 CITY-ST-ZIP	
TITLE	☐ DELETE	5.1 TITLE	☐ Change ☐ Addition
NAME		5.2 NAME	
STREET ADDRESS		5.3 STREET ADDRESS	
CITY-ST-ZIP		5.4 CITY-ST-ZIP	
TITLE	☐ DELETE	6.1 TITLE	☐ Change ☐ Addition
NAME		6.2 NAME	
STREET ADDRESS		6.3 STREET ADDRESS	
CITY-ST-ZIP		6.4 CITY-ST-ZIP	

14. I do 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 an attachment with an address.

SIGNATURE:


SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

3/26/97 (352)
5970907
Daytime Phone #

CR2E034 (9/96)