2004 FOR PROFIT CORPORATION ANNUAL REPORT

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Mar 31, 2004 8:00 am
Secretary of State
03-31-2004 90028 024 ***150.00

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02192004 Chg-P CR2E034 (10/03)

DOCUMENT # K96835

1. Entity Name
ATLANTIC COAST ANESTHESIA ASSOCIATES, P.A.

Principal Place of Business	Mailing Address
8247 BUSINESS PARK DR. P.O. BOX 7520 PORT ST. LUCIE, FL 34952	8247 BUSINESS PARK DR. P.O. BOX 7520 PORT ST. LUCIE, FL 34952

2. Principal Place of Business		3. Mailing Address	
8918 S. FEDERAL HWY		P.O. BOX 7520	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State: PORT ST LUCIE, FL		City & State: PORT ST LUCE, FL	
Zip: 34952	Country: USA	Zip: 34985	Country: USA

4. FEI Number: 65-0123516 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
INGRAM, KEITH MD 8247 BUSINESS PARK DR. PORT ST LUCIE, FL 34952	Name Street Address (P.O. Box Number is Not Acceptable) City **FL** Zip Code

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, 2004 Fee will be $550.00

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PTD INGRAM, KEITH MD 8247 BUSINESS PARK DR PORT ST LUCIE, FL ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition

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: Keith E Ingram, MD (Keith E. Ingram, MD) 3/15/4 (772) 335-2508
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #