


**2004 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Apr 14, 2004 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # L11160</b> 1. Entity Name HABANA MEDICAL CENTER, INC.	
---	---

Principal Place of Business 4700 N. HABANA AVENUE 504 TAMPA, FL 33614	Mailing Address 4700 N. HABANA AVENUE 504 TAMPA, FL 33614
--	--



04082004 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number 59-2970216	Applied For Not Applicable
-----------------------------	-------------------------------

5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
---	--------------------------------

6. Name and Address of Current Registered Agent  CARR, DAVID M 600 MADISON ST. TAMPA, FL 33602
--

**DO NOT WRITE  
IN THIS SPACE**

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. <input type="checkbox"/>	\$5.00 May Be Added to Fees
---	--------------------------------

U000000112542  
04/14/04-80027-024 150.00

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P WOOD, GARY L PSY.D. 4700 N HABANA AVE # TAMPA, FL 33614
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VPD COCKBURN, ALDEN MD 4700 N. HABANA AVE, STE 500 TAMPA, FL 33614
TITLE NAME STREET ADDRESS CITY-ST-ZIP	SD MCILWAIN, HARRIS MD 4700 N. HABANA AVE, STE 201 TAMPA, FL 33614
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	

**DO NOT WRITE  
IN THIS SPACE**

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:**  **GARY L WOOD Psy.D**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date \_\_\_\_\_ Daytime Phone # \_\_\_\_\_