

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

PROFIT
CORPORATION
ANNUAL REPORT
1996



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

DOCUMENT # **L43917** (8)

1. Corporation Name

GULF COAST PAIN MEDICINE CENTER, INC.



Principal Place of Business

**2344 BEE RIDGE RD
STE 100
SARASOTA FL 34239
US**

Mailing Address

**3945 HAMILTON CLUB CIR
SARASOTA FL 34242
US**

3. Date Incorporated or Qualified

01/22/1990

3a. Date of Last Report

03/03/1995

2. Principal Place of Business

2a. Mailing Address

21

26

4. FEI Number

65-0164436

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

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

**ORENS, SCOTT
3945 HAMILTON CLUB CIRCLE
SARASOTA FL 34242**

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 the applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE ☐ DELETE

**P
ORENS, SCOTT
3945 HAMILTON CLUB CR
SARASOTA FL**

1.1 TITLE ☐ Change ☐ Addition

NAME

12 NAME

STREET ADDRESS

13 STREET ADDRESS

CITY - ST - ZIP

14 CITY - ST - ZIP

TITLE ☐ DELETE

NAME

2.1 TITLE

STREET ADDRESS

22 NAME

CITY - ST - ZIP

23 STREET ADDRESS

TITLE ☐ DELETE

NAME

24 CITY - ST - ZIP

STREET ADDRESS

3.1 TITLE

CITY - ST - ZIP

32 NAME

STREET ADDRESS

33 STREET ADDRESS

TITLE ☐ DELETE

NAME

34 CITY - ST - ZIP

STREET ADDRESS

4.1 TITLE

CITY - ST - ZIP

42 NAME

STREET ADDRESS

43 STREET ADDRESS

TITLE ☐ DELETE

NAME

44 CITY - ST - ZIP

STREET ADDRESS

5.1 TITLE

CITY - ST - ZIP

52 NAME

STREET ADDRESS

53 STREET ADDRESS

TITLE ☐ DELETE

NAME

54 CITY - ST - ZIP

STREET ADDRESS

6.1 TITLE

CITY - ST - ZIP

62 NAME

STREET ADDRESS

63 STREET ADDRESS

TITLE ☐ DELETE

NAME

64 CITY - ST - ZIP

STREET ADDRESS

CITY - ST - ZIP

STREET ADDRESS

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 as an attachment with an address.

SIGNATURE:

Scott M. Orens President 3/7/96 (941) 927-1050

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (12/95)