


# 2005 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Mar 21, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # L72421</b> 1. Entity Name <b>EAST COAST ANESTHESIA ASSOCIATES, P.A.</b>					
Principal Place of Business <b>8918 S. FEDERAL HWY PORT ST. LUCIE, FL 34952 US</b>			Mailing Address <b>P O BOX 7520 PORT ST. LUCIE, FL 34985 US</b>		
2. Principal Place of Business		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country		
6. Name and Address of Current Registered Agent  <b>INGRAM, KEITH E M.D. 8247 BUSINESS PK DR PORT ST. LUCIE, FL 34952</b>				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> <span><b>FL</b></span> <span>Zip Code</span> </div>	
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 _____ (NOTE: Registered Agent signature required when reinstating) <small>Signature, typed or printed name of registered agent and title if applicable</small>					
<b>FILE NOW!!! FEE IS \$150.00</b> <b>After May 1, 2005 Fee will be \$550.00</b>		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/>		<b>\$5.00 May Be</b> <b>Added to Fees</b>	
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PDTC INGRAM, KEITH E M.D. 8247 BUSINESS PK DR PORT ST. LUCIE, FL		TITLE NAME STREET ADDRESS CITY - ST - ZIP	<div style="text-align: center;"> <b>UN00000271057</b>  <b>03/21/05-80032-004 150.00</b> </div>	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
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TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> 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.					
<b>SIGNATURE:</b> <u>Keith E Ingram MD</u> <b>KEITH E INGRAM MD</b> <u>3/17/05</u> <b>372-340-3080</b> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>					