

2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 30, 2004 8:00 am
Secretary of State

04-30-2004 90285 006 ***150.00

DOCUMENT # M40180 1. Entity Name TRAUMA CARE ASSOCIATES, INC.			
Principal Place of Business 3801 TURTLE CREEK DR #A212 CORAL SPRINGS, FL 33067		Mailing Address 8181 W BROWARD BLVD 255 PLANTATION, FL 33324	
2. Principal Place of Business <i>7667 West Sample Rd</i>		3. Mailing Address	
Suite, Apt. #, etc. <i>#213</i>		Suite, Apt. #, etc.	
City & State <i>Coral Springs, FL</i>		City & State	
Zip <i>33065</i>	Country <i>USA</i>	Zip	Country
6. Name and Address of Current Registered Agent BENNETT, KEITH CPA 8181 W BROWARD BLVD STE 255 PLANTATION, FL 33324		7. Name and Address of New Registered Agent 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 _____ (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	
10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D <input type="checkbox"/> Delete SICHEWSKI, VERNON 2841 N. OCEAN BLVD. FT. LAUDERDALE, FL	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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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: <i>V. Sichevsky, M.D.</i>		Date <i>4/28/04</i> Daytime Phone # <i>305 893 7250</i>	