


**2005 NOT-FOR-PROFIT CORPORATION
ANNUAL REPORT**

FILED
Jan 29, 2005 08:00 AM
Secretary of State

| | |
|--|---|
| DOCUMENT # N00000002903 1. Entity Name CHARLOTTE COUNTY MEDICAL MANAGEMENT ASSOCIATION, INC. |  |
|--|---|

Principal Place of Business
2421 SHREVE ST #113
PUNTA GORDA, FL 33950

Mailing Address
2421 SHREVE ST #113
PUNTA GORDA, FL 33950



01062005 No Chg-NP CR2E037 (10/03)

DO NOT WRITE IN THIS SPACE

| | |
|---|--|
| 4. FEI Number 65-1015581 | Applied For <input type="checkbox"/> Not Applicable |
| 5. Certificate of Status Desired <input type="checkbox"/> | \$8.75 Additional Fee Required |

6. Name and Address of Current Registered Agent

HARFST, MARY
2421 SHREVE ST #113
PUNTA GORDA, FL 33950

**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

**Filing Fee is \$61.25
Due by May 1, 2005**

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

| | |
|--|---|
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | PD HANDLEN, DOROTHY 3867 LUBEC AVE. NORTH PORT, FL 34287 |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | D HARFST, MARY 1626 ALABTROSS DR PUNTA GORDA, FL 33950 |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | DS FISHER, SHIRLOU 28007 N TWIN LAKES DR PUNTA GORDA, FL 33955 |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | |

U00000204107
01/29/05-80058-002 61.25

**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)(f), 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 617, 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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

1-7-05