


# 2005 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT (AR)

**FILED**  
**May 17, 2005 8:00 am**  
**Secretary of State**

05-17-2005 90013 045 \*\*\*\*61.25

|  |   |
|--|---|
| DOCUMENT # N00000007412  |  |
| 1. Entity Name   |   |
| THE DAVID M. BERNSTEIN, M.D., MEMORIAL MUSEUM OF MEDICAL HISTORY, INC. |   |

|   |   |
|---|---|
| Principal Place of Business   | Mailing Address   |
| C/O JACOB H. GOLDBERGER, M.D.<br>2675 WINKLER AVENUE SUITE 490<br>FORT MYERS FL 33901 | C/O JACOB H. GOLDBERGER, M.D.<br>2675 WINKLER AVENUE SUITE 490<br>FORT MYERS FL 33901 |



|  |                     |
|--|---------------------|
| 2. Principal Place of Business                   | 3. Mailing Address  |
| 13685 Doctors Way<br>Suite, Apt. #, etc.<br>#210 | Suite, Apt. #, etc. |
| City & State<br>Ft Myers, FL                     | City & State        |
| Zip<br>33912                                     | Country<br>Lee      |

1st MOORE CR2E037 (10/04)

|  |  |                                |
|--|--|--------------------------------|
| 4. FEI Number  |  | Applied For                    |
| 65-0977797   |  | Not Applicable                 |
| 5. Certificate of Status Desired <input type="checkbox"/>                      |  | \$8.75 Additional Fee Required |
| 6. Name and Address of Current Registered Agent                                |  |                                |
| GOLDBERGER, JACOB H MD<br>2675 WINKLER AVENUE SUITE 490<br>FORT MYERS FL 33901 |  |                                |
| 7. Name and Address of New Registered Agent                                    |  |                                |
| Name<br>Jacob H. Goldberger, M.D.  |  |                                |
| Street Address (P.O. Box Number is Not Acceptable)<br>13685 Doctors Way #210   |  |                                |
| City<br>Ft Myers, FL   |  |                                |
| Zip Code<br>33912  |  |                                |

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 \$61.25<br>Due By May 1, 2005 | 9. Election Campaign Financing<br>Trust Fund Contribution. <input type="checkbox"/> | \$5.00 May Be<br>Added to Fees | Make Check Payable to<br>Florida Department of State |
|--|---|--------------------------------|--|

| 10. OFFICERS AND DIRECTORS |                                   | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10 |   |
|----------------------------|-----------------------------------|---|---|
| TITLE                      | D <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | GOLDBERGER, JACOB H MD            | NAME  |   |
| STREET ADDRESS             | 2675 WINKLER AVE SUITE 490        | STREET ADDRESS  |   |
| CITY-ST-ZIP                | FORT MYERS FL 33901               | CITY-ST-ZIP   |   |
| TITLE                      | D <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | CASTELLANOS, RONALD D MD          | NAME  |   |
| STREET ADDRESS             | 2675 WINKLER AVE SUITE 490        | STREET ADDRESS  |   |
| CITY-ST-ZIP                | FORT MYERS FL 33901               | CITY-ST-ZIP   |   |
| TITLE                      | D <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | DOSORETZ, DANIEL MD               | NAME  |   |
| STREET ADDRESS             | 2675 WINKLER AVE SUITE 490        | STREET ADDRESS  |   |
| CITY-ST-ZIP                | FORT MYERS FL 33901               | CITY-ST-ZIP   |   |
| TITLE                      | D <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | SCOTT, ROGER MD                   | NAME  |   |
| STREET ADDRESS             | 2675 WINKLER AVE SUITE 490        | STREET ADDRESS  |   |
| CITY-ST-ZIP                | FORT MYERS FL 33901               | CITY-ST-ZIP   |   |
| TITLE                      | D <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | BUTLER, JOHN MD                   | NAME  |   |
| STREET ADDRESS             | 2675 WINKLER AVE SUITE 490        | STREET ADDRESS  |   |
| CITY-ST-ZIP                | FORT MYERS FL 33901               | CITY-ST-ZIP   |   |
| TITLE                      | D <input type="checkbox"/> Delete | TITLE   | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME                       | GAAR, DAVID G MD                  | NAME  |   |
| STREET ADDRESS             | 2675 WINKLER AVE SUITE 490        | STREET ADDRESS  |   |
| CITY-ST-ZIP                | FORT MYERS FL 33901               | CITY-ST-ZIP   |   |

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 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:  DATE: 3/31/05 (239) 274-7600