

# 2004 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT (AR)

**FILED**  
**Mar 15, 2004 8:00 am**  
**Secretary of State**

03-15-2004 90052 012 \*\*\*\*61.25

DOCUMENT # N03000001250

1. Entity Name

EAST FLORIDA PHYSICIAN ALLIANCE, INC.



Principal Place of Business

Mailing Address

C/O ONE SOURCE HEALTH NETWORK OF SOUTH  
IDA 4101 HOSPITAL DR STE 1  
PLANTATION FL 33317

C/O ONE SOURCE HEALTH NETWORK OF SOUTH  
IDA 4101 HOSPITAL DR STE 1  
PLANTATION FL 33317

24022340



MOORE

CR2E037 (11/03)

2. Principal Place of Business

4101 S. Hospital Drive

Suite, Apt. #, etc.

Suite 1

City & State

Zip

Country

3. Mailing Address

4101 S. Hospital Drive

Suite, Apt. #, etc.

Suite 1

City & State

Zip

Country

4. FEI Number

55-0827870 EFN

Applied For

Not Applicable

5. Certificate of Status Desired

☐

\$8.75 Additional  
Fee Required

6. Name and Address of Current Registered Agent

FARRELL, JAMES A  
STE 500, 250 S AUSTRALIAN AVE  
W PALM BEACH FL 33401

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

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW: FEE IS \$61.25**  
**Due By May 1, 2004**

9. Election Campaign Financing  
Trust Fund Contribution.

☐

**\$5.00 May Be  
Added to Fees**

**Make Check Payable to  
Florida Department of State**

10. OFFICERS AND DIRECTORS

TITLE D ☐ Delete  
NAME KATZMAN, HOWARD M.D.  
STREET ADDRESS ~~401 HOSPITAL DR STE 1~~ 4101 S. Hospital Dr.  
CITY-ST-ZIP PLANTATION FL 33317 STE 1

TITLE D ☐ Delete  
NAME SCHULTZ, NEIL M.D.  
STREET ADDRESS ~~401 HOSPITAL DR STE 1~~  
CITY-ST-ZIP PLANTATION FL 33317

TITLE D ☐ Delete  
NAME BORNIA, MANUEL M.D.  
STREET ADDRESS ~~401 HOSPITAL DR STE 1~~  
CITY-ST-ZIP PLANTATION FL 33317

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE ☒ Change ☐ Addition  
NAME  
STREET ADDRESS 4101 S. Hospital Dr. Suite 1  
CITY-ST-ZIP

TITLE ☒ Change ☐ Addition  
NAME  
STREET ADDRESS 4101 S. Hospital Dr. Suite 1  
CITY-ST-ZIP

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TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #