

2005 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # N03000003108

1. Entity Name
PRIMARY CARE MEDICAL SERVICES OF POINCIANA,
INC.



Principal Place of Business
1875 BOGGY CREEK ROAD
KISSIMMEE, FL 34744

Mailing Address
1875 BOGGY CREEK ROAD
KISSIMMEE, FL 34744

FILED
05 AUG 24 AM 10: 57
SECRETARY OF STATE
TALLAHASSEE, FLORIDA



07112005 No Chg-NP CR2E037 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number
75-3147007

Applied For
Not Applicable

5. Certificate of Status Desired ☐ \$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

BARRY, MARY ANN
614 KOALA COURT
KISSIMMEE, FL 34759

**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 Mary Ann Barry Mary Ann Barry 7/11/05
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 September 7, 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	C BARRY, MARY ANN 614 KOALA COURT KISSIMMEE, FL 34759
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VC BRAUER, BERNADETTE 240 CHURCHILL COURT KISSIMMEE, FL 34758
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T KATAN, DAVID 316 FERRARA COURT KISSIMMEE, FL 34758
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D NOAD, KEITH 1902 ISLAND CIRCLE., #202 KISSIMMEE, FL 34741
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D WATSON, ARNIM 707 TOLTEC PL KISSIMMEE, FL 34758
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D BELISLE, WILDA 856 E. FLAG LANE KISSIMMEE, FL 34759

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IN THIS SPACE**

8/28/24

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: Mary Ann Barry Mary Ann Barry 7/11/05 8634221571
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

STATE OF FLORIDA

VOUCHER SCHEDULE

DATE 08/19/2005

S-W/Agency Voucher No.

OLO 640000

JT-2

**D60-0009-2045
000089**

DEPARTMENT OSCEOLA COUNTY HEALTH DEPARTMENT

SITE OSCEOLA CHD - VALARIE MOORE

CFO ACCOUNT NUMBER	CF	OBJECT CODE	TRANS CODE 25	TRANS CODE 45
CFO ACCOUNT NAME				
INVOICE	INVOICE AMOUNT		INCREASE AMOUNT	INCREASE AMOUNT
64202141001-6420070049-04000000		4930	61.25	
COUNTY HEALTH DEPARTMENT TRUST EXPENSES				
INV: N03000003	61.25			
45101000132-4530010000-00010000				61.25
GENERAL REVENUE FUND FEES				

TRANSACTION TYPE: JOURNAL ADVICE

TOTAL

TOTAL

61.25

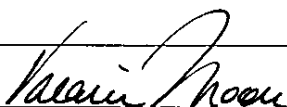
61.25

I hereby certify that the above transactions are in accordance with the Florida Statutes and all applicable laws and rules of the State of Florida.

For CFO Use Only

Time In

APPROVED:



Audited By

TITLE

Acct Ser Supervisor