

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

FILED

2005 AUG 24 PM 4:55

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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



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

Mary Ann Barry
(NOTE: Registered Agent signature required when reinstating)

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

**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)(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 #

Mary Ann Barry *Mary Ann Barry* 7/11/05 8634271571

024

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

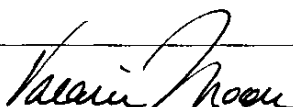
CFO ACCOUNT NUMBER	CF	OBJECT CODE	TRANS CODE	TRANS CODE
	CFO ACCOUNT NAME		25	45
	INVOICE		INCREASE AMOUNT	INCREASE AMOUNT
64202141001-6420070049-04000000	COUNTY HEALTH DEPARTMENT TRUST EXPENSES	4930	61.25	
INV: N03000003	61.25			
45101000132-4530010000-00010000	GENERAL REVENUE FUND FEES			61.25
TRANSACTION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



TITLE

Acct Ser Supervisor

Audited By