


2008 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

FILED
Aug 12, 2008 8:00 am
Secretary of State

08-12-2008 90024 041 ****61.25

| | | | | | |
|--|---|--|--|--|---|
| DOCUMENT # N49671 1. Entity Name CITRUS COUNTY MEDICAL SOCIETY, INC. | | | |  | |
| Principal Place of Business 131 SOUTH CITRUS AVE 303 INVERNESS, FL 34452 US | | | Mailing Address PO BOX 2601 INVERNESS, FL 34451 US | | |
| 2. Principal Place of Business - No P.O. Box # 521 N. LECANTO HWY | | 3. Mailing Address Suite, Apt. #, etc. | | | |
| Suite, Apt. #, etc. | | Suite, Apt. #, etc. | | | |
| City & State LECANTO, FL | | City & State | | 4. FEI Number 59-1582682 | |
| Zip 34461 | | Country US | | 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required | |
| 6. Name and Address of Current Registered Agent LOCKLEAR, MARCIA 131 SOUTH CITRUS AVE 303 INVERNESS, FL 34452 | | | 7. Name and Address of New Registered Agent Name GUSTAVO FONSECA MD Street Address (P.O. Box Number is Not Acceptable) 521 N. LECANTO HWY City LECANTO FL Zip Code 34461 | | |
| 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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small> | | | | | |
| Filing Fee is \$61.25 Due by September 12, 2008 | | 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> | | \$5.00 May Be Added to Fees | |
| Make check payable to Florida Department of State | | | | | |
| 10. OFFICERS AND DIRECTORS | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10 | | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | D HARRER, WILLIAM MD 501 MEDICAL CT. INVERNESS, FL 34452 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | SD FONSECA, GUSTAVO A MD 521 NORTH LECANTO HWY LECANTO, FL 34461 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | TD BELLAM, RAJENDRA P MD 11707 N WILLIAMS ST DUNNELLON, FL 34432 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Delete | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
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| 12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small> | | | 8/8/08 352 746 0707 <small>Date Daytime Phone #</small> | | |