

2004 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

FILED
Jul 12, 2004 8:00 am
Secretary of State

07-12-2004 90032 033 ****61.25

DOCUMENT # N92000000633

1. Entity Name
**CHARLOTTE COUNTY PHYSICIAN-HOSPITAL
ORGANIZATION, INC.**



Principal Place of Business
**21298 OLEAN BLVD
PORT-CHARLOTTE, FL 33952**

Mailing Address
**21298 OLEAN BOULEVARD
P.O. BOX 494960
PORT CHARLOTTE, FL 33949-4960 US**



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

06302004

Chg-NP

CR2E037 (10/03)

City & State

City & State

4. FEI Number

65-0379742

Applied For

Not Applicable

Zip

Country

Zip

Country

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**FAWCETT MEMORIAL HOSPITAL
21298 OLEAN BLVD
PORT CHARLOTTE, FL 33952**

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

**Filing Fee is \$61.25
Due by September 8, 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

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE **P** ☐ Delete
NAME **BUTLER, JOE MD**
STREET ADDRESS **21298 OLEAN BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE, FL**

TITLE **D** ☐ Change ☒ Addition
NAME **SAKINA KHALIDI MD**
STREET ADDRESS **2400 HARBOR BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE FL**

TITLE **V** ☐ Delete
NAME **BALLESTAS, DAVID MD**
STREET ADDRESS **21298 OLEAN BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE, FL**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE **ST** ☐ Delete
NAME **BURNS, JAMES P. III**
STREET ADDRESS **21298 OLEAN BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE, FL**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE **D** ☐ Delete
NAME **ESCHLEMAN, ROBERT MD**
STREET ADDRESS **21298 OLEAN BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE, FL 33952**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE **D** ☐ Delete
NAME **AMONTREE, JAMES**
STREET ADDRESS **21298 OLEAN BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE, FL 33952**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE **D** ☒ Delete
NAME **STRINE, SCOTT MD**
STREET ADDRESS **21298 OLEAN BLVD.**
CITY-ST-ZIP **PORT CHARLOTTE, FL**

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

JAMES P. BURNS III

7/8/04

Date

941-627-8182

Daytime Phone #