


2005 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 11, 2005 8:00 am
Secretary of State

04-11-2005 90153 023 ****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.			
City & State		City & State			
Zip	Country	Zip	Country	4. FEI Number 65-0379742	
				Applied For <input type="checkbox"/> Not Applicable	
				5. Certificate of Status Desired <input type="checkbox"/> \$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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____					
Filing Fee is \$61.25 Due by May 1, 2005		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	P BUTLER, JOE MD 21298 OLEAN BLVD. PORT CHARLOTTE, FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	D VOLLBERG, CARLTON 21298 OLEAN BLVD PORT CHARLOTTE, FL 33952 <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V BALLESTAS, DAVID MD 21298 OLEAN BLVD. PORT CHARLOTTE, FL <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	ST BURNS, JAMES P III. 21298 OLEAN BLVD. PORT CHARLOTTE, FL <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	D ESCHLEMAN, ROBERT MD 21298 OLEAN BLVD. PORT CHARLOTTE, FL 33952 <input checked="" 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	D AMONTREE, JAMES 21298 OLEAN BLVD. PORT CHARLOTTE, FL 33952 <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	D KHALIDI, SAKINA MD 2400 HARBOR BLVD. PORT CHARLOTTE, FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
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: <i>James P. Burns</i> JAMES P. BURNS <i>4/14/05</i> 941-629-1181					
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR _____ Date _____ Daytime Phone # _____					