FILE NOW: FILING FEE IS $61.25

NONPROFIT CORPORATION ANNUAL REPORT **1997**		FLORIDA DEPARTMENT OF STATE **Sandra B. Mortham** Secretary of State DIVISION OF CORPORATIONS

DOCUMENT #   N93000005733 (1)

1. Corporation Name

MARTIN MEMORIAL PHYSICIAN-HOSPITAL ORGANIZATION, INC.

Principal Place of Business	Mailing Address
301 HOSPITAL AVE STUART FL 34994 US	P O BOX 9010 STUART FL 34995-9010 US

3. Date Incorporated or Qualified **12/22/1993**	3a. Date of Last Report **06/03/1996**

2. Principal Place of Business	2a. Mailing Address	4. FEI Number **65-0466177**	Applied For / Not Applicable
21	26		
Suite, Apt. #, etc. 22	Suite, Apt. #, etc. 27	5. Certificate of Status Desired ☐	**$8.75** Additional Fee Required
City & State 23	City & State 28	6. Election Campaign Financing Trust Fund Contribution ☐	**$5.00** May Be Added to Fees
Zip 24	Country 25	Zip 29	Country 30
			8. This corporation has liability for intangible tax under s. 199.032, Florida Statutes ☐ Yes ☐ No

9. Name and Address of Current Registered Agent	10. Name and Address of New Registered Agent
HARMAN, RICHMOND 301 HOSPITAL AVE STUART FL 34494	81 Name 82 Street Address (P.O. Box Number is Not Acceptable) 83 84 City FL 85 Zip Code

11. Pursuant to the provisions of Sections 617.0502 and 617.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 617.0503, Florida Statutes.

SIGNATURE _____

Signature, typed or printed name of registered agent and title if applicable.   (NOTE: Registered Agent signature required when reinstating)   DATE

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE **D** ☐ DELETE NAME **ULANO, HARVEY** STREET ADDRESS **500 E. OSCEOLA ST.** CITY-ST-ZIP **STUART FL 34994**		1.1 TITLE 1.2 NAME 1.3 STREET ADDRESS 1.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE **CD** ☐ DELETE NAME **BEATTY, MARK MD** STREET ADDRESS **931 E. OCEAN BLVD. STE C** CITY-ST-ZIP **STUART FL 34994**		2.1 TITLE 2.2 NAME 2.3 STREET ADDRESS 2.4 CITY-ST-ZIP	☐ Change ☐ Addition
TITLE **PD** ☐ DELETE NAME **COCORULLO, L. M.** STREET ADDRESS **301 HOSPITAL AVE** CITY-ST-ZIP **STUART FL**		3.1 TITLE PD 3.2 NAME Cocorullo, L.M. 3.3 STREET ADDRESS 301 Hospital Ave. 3.4 CITY-ST-ZIP Stuart, Fl 34994	☒ Change ☐ Addition
TITLE **D** ☐ DELETE NAME **COLLIN, ALAN MD** STREET ADDRESS **509 RIVERSIDE DR., #200** CITY-ST-ZIP **STUART FL 34994**		4.1 TITLE 4.2 NAME 4.3 STREET ADDRESS 4.4 CITY-ST-ZIP	☐ Change ☒ Addition
TITLE **TD** ☒ DELETE NAME **CROUTHAMEL, LAWRENCE MD** STREET ADDRESS **509 RIVERSIDE DR., SUITE 206** CITY-ST-ZIP **STUART FL**		5.1 TITLE TD 5.2 NAME Whitaker, David MD 5.3 STREET ADDRESS 900 E. Ocean Blvd, Ste 200 5.4 CITY-ST-ZIP Stuart, Fl 34994	☐ Change ☒ Addition
TITLE **D** ☐ DELETE NAME **HARMAN, RICHMOND M** STREET ADDRESS **301 HOSPITAL AVE** CITY-ST-ZIP **STUART FL 34994**		6.1 TITLE 6.2 NAME 6.3 STREET ADDRESS 6.4 CITY-ST-ZIP	☐ Change ☐ Addition

14. I do 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: _____ SIGNATURE REQUIRED

CR2E037 (9/96)