


2006 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Mar 22, 2006 8:00 am
Secretary of State

03-08-2006 90173 018 ****61.25

DOCUMENT # N95000001677 1. Entity Name FLORIDA ASSOCIATION OF RURAL HEALTH CLINICS, INC.					
Principal Place of Business 225 US HWY 27 SOUTH LAKE PLACID FL 33852			Mailing Address POST OFFICE BOX 3267 LAKE PLACID FL 33862		
2. Principal Place of Business Suite, Apt. #, etc.			3. Mailing Address Suite, Apt. #, etc.		
City & State			City & State		
Zip		Country		Zip	
Country		Country		4. FEI Number 65-0576197	
5. Certificate of Status Desired <input type="checkbox"/>				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent GOSSMAN, JEANNE G 225 US HIGHWAY 27 SOUTH LAKE PLACID FL 33852				7. Name and Address of New Registered Agent Name JEANNE GOSSMAN Street Address (P.O. Box Number is Not Acceptable) 575 CARLTON STREET City WAUCHULA FL 33873	
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 <u><i>Jeanne Gosman</i></u> DATE <u>2-20-06</u> <small>Signature, typed or printed name of registered agent with title (if applicable) (NOTE: Registered Agent signature required when filing)</small>					
FILE NOW - FEE IS \$61.25 Due By May 1, 2006		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	TS GOSSMAN, JEANNE G 225 US HWY., 27 SOUTH LAKE PLACID FL 33852	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY - ST - ZIP	575 CARLTON STREET WAUCHULA, FL 33873
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D CETIN, KEN 1110 E GIBSON ST ARCADIA FL 33821	<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 GLASS, GREG 1203 GOVERNS SQUARE BLVD STE. 302 TALLAHASSEE FL 32301	<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 TILLMAN, MARY ALICE 5229 WEST GALA LANE DUNNELLON FL 34433	<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	P WEBER, MARYLOU 7205 NW 47TH COURT GAINESVILLE FL 32606	<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
12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 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: <u><i>Jeanne Gosman</i></u> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>			<u>3-20-06</u> <i>Treasurer</i> <small>Date</small>		



ATTACHMENT
66006399

FLORIDA DEPARTMENT OF STATE
Division of Corporations

March 10, 2006

FLORIDA ASSOCIATION OF RURAL HEALTH CLINICS, INC.
POST OFFICE BOX 3267
LAKE PLACID, FL 33862

Subject: **FLORIDA ASSOCIATION OF RURAL HEALTH CLINICS, INC.**

Reference Number: **N95000001677**

Please be advised, we have received your annual report/uniform business report and your check(s) totaling \$61.25; however, the report **has not been filed** and a copy is being returned for the following correction(s):

The annual report/uniform business report must be signed by an officer or director of the corporation.

After the corrections have been made, please return the report to: Division of Corporations, P.O. Box 1500, Tallahassee, Florida 32302-1500 within 30 days from the date of this letter.

If you have additional questions or need further assistance, please call the Division of Corporations at 850-245-6056 and press 4. Your call will be answered in the order it is received.

/MH
ANNUAL REPORTS SECTION

Re Submitted
3-20-06
with signature