

FILE NOW: FILING FEE IS \$61.25

FILED

Jan 30 1998 8:00am  
Secretary of State

NONPROFIT CORPORATION ANNUAL REPORT <b>1998</b>		FLORIDA DEPARTMENT OF STATE <b>Sandra B. Mortham</b> Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # **N95000001887 (7)**

1. Corporation Name

**PALM BEACH COUNTY RADIOLOGICAL SOCIETY, INC.**



Principal Place of Business	Mailing Address
40 RIVER DR TEQUESTA FL 33469 US	40 RIVER DR TEQUESTA FL 33469 US

3. Date Incorporated or Qualified  
**04/20/1995**

4. FEI Number  
**65-0579312**

Applied For  
Not Applicable

2. Principal Place of Business	2a. Mailing Address
21 Suite, Apt. #, etc.	26 Suite, Apt. #, etc.
22 City & State	27 City & State
23 Zip	28 Zip
24 Country	29 Country
25	30

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**

6. Election Campaign Financing Trust Fund Contribution ☐ **\$5.00 May Be Added to Fees**

7. Is this nonprofit corporation a homeowners association? ☐ Yes ☒ No

8. This corporation owes or has paid the current year Intangible Personal Property Tax due June 30. ☐ Yes ☒ No

9. Name and Address of Current Registered Agent

**BRUCE RODAN, MD**  
**40 RIVER DR**  
**TEQUESTA FL 33469**

10. Name and Address of New Registered Agent

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 <input type="checkbox"/> DELETE	1.1 TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	SPUNBERG, JEROME J M.D.	1.2 NAME	
STREET ADDRESS	171 COMMODORE DR	1.3 STREET ADDRESS	
CITY-ST-ZIP	JUPITER FL	1.4 CITY-ST-ZIP	<b>33477</b>
TITLE	D <input type="checkbox"/> DELETE	2.1 TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	SIMON, BARRY M.D.	2.2 NAME	
STREET ADDRESS	109 QUAYSIDE DR	2.3 STREET ADDRESS	
CITY-ST-ZIP	JUPITER FL	2.4 CITY-ST-ZIP	<b>33477</b>
TITLE	D <input type="checkbox"/> DELETE	3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	BAUMEL, ERIC M.D.	3.2 NAME	
STREET ADDRESS	14791 FARRIER PL	3.3 STREET ADDRESS	
CITY-ST-ZIP	WELLINGTON FL	3.4 CITY-ST-ZIP	
TITLE	D <input type="checkbox"/> DELETE	4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	KATIMS, LEE M	4.2 NAME	
STREET ADDRESS	2195 ST. CHARLES WAY	4.3 STREET ADDRESS	
CITY-ST-ZIP	BOCA RATON FL 33434	4.4 CITY-ST-ZIP	
TITLE	D <input type="checkbox"/> DELETE	5.1 TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	RODAN, BRUCE M.D.	5.2 NAME	
STREET ADDRESS	40 RIVER DR	5.3 STREET ADDRESS	
CITY-ST-ZIP	TEQUESTA FL	5.4 CITY-ST-ZIP	<b>33469</b>
TITLE	<input type="checkbox"/> DELETE	6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		6.2 NAME	
STREET ADDRESS		6.3 STREET ADDRESS	
CITY-ST-ZIP		6.4 CITY-ST-ZIP	

14. 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 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:

*BRUCE A RODAN, MD*  
**SIGNATURE REQUIRED**

BRUCE A RODAN, MD

JAN 8, 98

5616270665

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