


2004 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 10, 2004 8:00 am
Secretary of State

03-10-2004 90026 043 ****61.25

DOCUMENT # N96000001105

1. Entity Name
MEDICAL DOCTORS' RESEARCH INSTITUTE, INC.



Principal Place of Business
**14101 NW 4TH ST
 SUNRISE, FL 33325**

Mailing Address
**14101 NW 4TH ST
 SUNRISE, FL 33325**



2. Principal Place of Business
 Suite, Apt. #, etc.

3. Mailing Address
 Suite, Apt. #, etc.

01172004 Chg-NP CR2E037 (10/03)

City & State

4. FEI Number
65-0572002

Applied For
 Not Applicable

Zip Country

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

6. Name and Address of Current Registered Agent

**RILEY, PATRICIA A
 14101 NW 4TH ST
 SUNRISE, FL 33325**

7. Name and Address of New Registered Agent

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

**Filing Fee is \$61.25
 Due by May 1, 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

| | |
|----------------|------------------------------------|
| TITLE | PD <input type="checkbox"/> Delete |
| NAME | RILEY, JAMES |
| STREET ADDRESS | 14101 NW 4TH ST |
| CITY-ST-ZIP | SUNRISE, FL 33325 |
| TITLE | DV <input type="checkbox"/> Delete |
| NAME | RILEY, PATRICIA |
| STREET ADDRESS | 14101 NW 4TH ST |
| CITY-ST-ZIP | SUNRISE, FL 33325 |
| TITLE | D <input type="checkbox"/> Delete |
| NAME | RILEY, FRANCIS X |
| STREET ADDRESS | 14101 N.W. 4 ST. |
| CITY-ST-ZIP | SUNRISE, FL |
| TITLE | <input type="checkbox"/> Delete |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |
| TITLE | <input type="checkbox"/> Delete |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |
| TITLE | <input type="checkbox"/> Delete |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

| | |
|----------------|---|
| TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |
| TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |
| TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |
| TITLE | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | |
| STREET ADDRESS | |
| CITY-ST-ZIP | |
| TITLE | <input type="checkbox"/> Change <input type="checkbox"/> 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: _____ **2/9/04** **954-845-9520**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #