

**2006 NOT-FOR-PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 15, 2006 08:00 AM
Secretary of State

DOCUMENT # N97000004822

1. Entity Name
**ORMOND BEACH AMBULATORY SURGICAL CENTER
OWNERS ASSOCIATION, INC.**



Principal Place of Business
**300 CLYDE MORRIS BOULEVARD
SUITE B
ORMOND BEACH, FL 32174**

Mailing Address
**300 CLYDE MORRIS BOULEVARD
SUITE B
ORMOND BEACH, FL 32174**



02132006 No Chg-NP CR2E037 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number **59-3504153** Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

**PALMETTO CHARTER SERVICES, INC.
150 MAGNOLIA AVENUE
DAYTONA BEACH, FL 32114**

**DO NOT WRITE
IN THIS SPACE**

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

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

**Filing Fee is \$61.25
Due by May 1, 2006**

9. Election Campaign Financing
Trust Fund Contribution. ☐

**\$5.00 May Be
Added to Fees**

10. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
**DVP
DHAND, ARUN MD
300 CLYDE MORRIS BLVD. SUITE A
ORMOND BEACH, FL 32174**

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
**DST
RINER, MARK MD
300 CLYDE MORRIS BLVD. SUITE A
ORMOND BEACH, FL 32174**

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
**DP
MORROW, BERT MD
300 CLYDE MORRIS BLVD. SUITE C
ORMOND BEACH, FL 32174**

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
**D
PARR, GREGORY MD
300 CLYDE MORRIS BLVD. SUITE C
ORMOND BEACH, FL 32174**

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

000000434729
02/25/06-80012-025 61.25

**DO NOT WRITE
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Bert M. Morrow, M.D., President

2/13/2006 386-673 5100

Date

Daytime Phone #