

# 2005 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Mar 25, 2005 8:00 am**  
**Secretary of State**

03-25-2005 90035 018 \*\*\*150.00

<b>DOCUMENT # P00000034861</b> 1. Entity Name <b>CERTIFIED SURGICAL ASSISTANTS P.A. INC.</b>					
Principal Place of Business <b>13429 PAM DR. BROOKSVILLE, FL 34614</b>			Mailing Address <b>13429 PAM DR. BROOKSVILLE, FL 34614</b>		
2. Principal Place of Business <b>8912 RIVERLACHEN WAY</b>		3. Mailing Address <b>8912 RIVERLACHEN WAY</b>			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State <b>RIVERVIEW, FL.</b>		City & State <b>RIVERVIEW, FL.</b>		4. FEI Number <b>65-1011971</b>	
Zip <b>33569</b>		Country <b>HILLSBOROUGH</b>		5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75</b> Additional Fee Required	
6. Name and Address of Current Registered Agent  <b>MOUNT, JAMES A 13429 PAM DR. BROOKSVILLE, FL 34614</b>		7. Name and Address of New Registered Agent Name <b>JAMES A. MOUNT</b> Street Address (P.O. Box Number is Not Acceptable) <b>8912 RIVERLACHEN WAY</b> City <b>RIVERVIEW</b> <b>FL</b> Zip Code <b>33569</b>			
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 <i>James A. Mount CRNFA</i> <small>Signature, typed or printed name of registered agent and title if applicable.</small>		<b>JAMES A. MOUNT CRNFA</b>		<b>PRESIDENT</b>	
<b>FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00</b>		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00</b> May Be Added to Fees		<b>03/12/2005</b> <small>DATE</small>	
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>P</b> <b>MOUNT, JAMES A</b> <b>13429 PAM DR</b> <b>BROOKSVILLE, FL 34614</b>		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>8912 RIVERLACHEN WAY</b> <b>RIVERVIEW, FL. 33569</b>	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<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		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<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 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 607, 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: <i>James A. Mount CRNFA</i> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>		<b>JAMES A. MOUNT CRNFA</b>		<b>PRESIDENT</b>	
<b>03/12/2005</b> <small>Date</small>		<b>03/12/2005</b> <small>Daytime Phone #</small>			