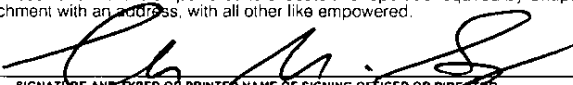


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 07, 2008 8:00 am
Secretary of State

04-07-2008 90051 043 ***150.00

| | | | | | |
|---|---------------------------------|--|---|--|--|
| DOCUMENT # P00000057017 | | | |  | |
| 1. Entity Name OPTOMETRIC ASSOCIATES OF OCALA, INC. | | | | | |
| Principal Place of Business 1500 SE MAGNOLIA EXTENSION SUITE 106 OCALA, FL 34471 | | | Mailing Address 1500 SE MAGNOLIA EXTENSION SUITE 106 OCALA, FL 34471 | | |
| 2. Principal Place of Business - No P.O. Box # 3130 SW 32nd Ave | | 3. Mailing Address Same As Principal | | | |
| Suite, Apt. #, etc. | | Suite, Apt. #, etc. | | | |
| City & State Ocala FL | | City & State | | 4. FEI Number 59-3651476 | |
| Zip 34474 | | Country USA | | 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required | |
| 6. Name and Address of Current Registered Agent MORRIS, MICHAEL 1500 SE MAGNOLIA EXTENSION SUITE 106 OCALA, FL 34471 | | | 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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____ | | | | | |
| FILE NOW!!! - FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00 | | | 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees | | |
| 10. OFFICERS AND DIRECTORS | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | | |
| TITLE S/D NAME SAMY, CHANDER MD STREET ADDRESS 1500 SE MAGNOLIA EXTENSION SUITE 106 CITY-ST-ZIP OCALA, FL 34471 | <input type="checkbox"/> Delete | | TITLE NAME Address Change STREET ADDRESS 3130 SW 32nd Ave CITY-ST-ZIP Ocala FL 34474 | <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE P/D NAME SCHWENK, GORDON C MD STREET ADDRESS 1500 SE MAGNOLIA EXTENSION SUITE 106 CITY-ST-ZIP OCALA, FL 34471 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE VP/D NAME POLACK, PETER J MD STREET ADDRESS 1500 SE MAGNOLIA EXTENSION SUITE 106 CITY-ST-ZIP OCALA, FL 34471 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE P/D NAME DEATON, JOHN S DO STREET ADDRESS 1500 SE MAGNOLIA EXTENSION SUITE 106 CITY-ST-ZIP OCALA, FL 34471 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE VP/D NAME JANK, MARK A MD STREET ADDRESS 1500 SE MAGNOLIA EXTENSION SUITE 106 CITY-ST-ZIP OCALA, FL 34471 | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE T/D NAME MORRIS, H. MICHAEL MD STREET ADDRESS 1500 SE MAGNOLIA EXTENSION SUITE 106 CITY-ST-ZIP OCALA, FL 34471 | <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 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 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:  | | | 4.3.08 352-622-5183 | | |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR | | | Date Daytime Phone # | | |