


# 2007 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Jan 17, 2007 8:00 am**  
**Secretary of State**

01-17-2007 90051 024 \*\*\*150.00

<b>DOCUMENT # P01000047060</b> 1. Entity Name NEW HORIZONS: WOMEN'S MEDICAL GROUP, P.A.					
Principal Place of Business 3901 UNIVERSITY BLVD SOUTH STE 215 JACKSONVILLE, FL 32216			Mailing Address 3901 UNIVERSITY BLVD SOUTH STE 215 JACKSONVILLE, FL 32216		
2. Principal Place of Business - No P.O. Box #  Suite, Apt. #, etc.		3. Mailing Address  Suite, Apt. #, etc.			
City & State  Zip      Country		City & State  Zip      Country		4. FEI Number 59-3719173 Applied For <input type="checkbox"/> Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required				01092007      Chg-P      CR2E034 (12/06)	
6. Name and Address of Current Registered Agent  WILLIS, DEBRA K 3901 UNIVERSITY BLVD SOUTH STE 215 JACKSONVILLE, FL 32216			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 <u>Debra K. Willis</u> DATE <u>01/11/07</u> <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>					
<b>FILE NOW!!! FEE IS \$150.00</b> <b>After May 1, 2007 Fee will be \$550.00</b>		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 NAME STREET ADDRESS CITY-ST-ZIP	D MARTIN, ANGELA S 4205 BELFORT RD., STE. 2004 JACKSONVILLE, FL 32216	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	3901 University Blvd. So, Ste 215 Jacksonville, FL 32216
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D MACKSEY, JOAN M 4205 BELFORT RD., STE. 2004 JACKSONVILLE, FL 32216	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	3901 University Blvd. So, Ste 215 Jacksonville, FL 32216
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	
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 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: <u>Amirah</u> <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>			Date <u>01/11/07</u> Daytime Phone # <u>904-296-3200</u>		