


**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
May 06, 2004 08:00 AM
Secretary of State

DOCUMENT # P01000094574 1. Entity Name S M P MEDICAL SERVICES CORP.	
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Principal Place of Business 4471 NW 36 ST 231 MIAMI, FL 33166	Mailing Address 4471 NW 36 ST 231 MIAMI, FL 33166
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DO NOT WRITE IN THIS SPACE



05032004 No Chg-P CR2E034 (10/03)

4. FEI Number 65-1140565	Applied For Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
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6. Name and Address of Current Registered Agent

POZO, FRANK
4471 NW 36 ST 231
MIAMI, FL 33166

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

FILE NOW!!! FEE IS \$150.00 Due by September 8, 2004	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.
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10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD POZO, FRANK 4471 NW 36ST 231 MIRAMAR, FL 33023
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05/06/04-80031-002 150.00

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IN THIS SPACE**

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: _____
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date _____ Daytime Phone # _____