

**2006 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Apr 19, 2006 08:00 AM**  
**Secretary of State**

**DOCUMENT # P01000106946**

1. Entity Name  
**SEBASTIAN RIVER ANESTHESIOLOGY ASSOCIATES,  
P.A.**



Principal Place of Business  
**4054 BEAVER LANE, #7  
PORT CHARLOTTE, FL 33952**

Mailing Address  
**P.O. BOX 510626  
PUNTA GORDA, FL 33951**



03142006 No Chg-P CR2E034 (11/05)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number  
**65-1153590** Applied For  
Not Applicable

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

**6. Name and Address of Current Registered Agent**

**KAPLAN, HAROLD E ESQ.  
1515 UNIVERSITY DRIVE  
CORAL SPRINGS, FL 33071**

**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

**FILE NOW!!! FEE IS \$150.00  
After May 1, 2006 Fee will be \$550.00**

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  
**D  
POLLIZZI, ANTHONY  
P.O. BOX 510626  
PUNTA GORDA, FL 339510626**

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

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U00000519332  
05/02/06-80050-001 150.00

**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 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with an other life empowered.

**SIGNATURE:**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**Anthony Pollizzi 4-17-06 941-575-8227**

Date

Daytime Phone #