

# 2004 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT# P01000115311

**FILED**  
**Jan 08, 2004**  
**Secretary of State**

**Entity Name:** CENTER FOR PHYSICIANS CARE, INC.

**Current Principal Place of Business:**

1040 SEMINOLE CREEK DRIVE  
OVIEDO, FL 32765

**New Principal Place of Business:**

**Current Mailing Address:**

PO BOX 678705  
ORLANDO, FL 328678705

**New Mailing Address:**

**FEI Number:** 59-3760975

**FEI Number Applied For ( )**

**FEI Number Not Applicable ( )**

**Certificate of Status Desired (X)**

**Name and Address of Current Registered Agent:**

THORNTON, DAMON D  
1040 SEMINOLE CREEK DRIVE  
OVIEDO, FL 32765

**Name and Address of New Registered Agent:**

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.

SIGNATURE: \_\_\_\_\_

Electronic Signature of Registered Agent

\_\_\_\_\_ Date

**Election Campaign Financing Trust Fund Contribution ( ).**

**OFFICERS AND DIRECTORS:**

Title: P ( ) Delete  
Name: THORNTON, DAMON D  
Address: 1040 SEMINOLE CREEK DRIVE  
City-St-Zip: OVIEDO, FL 32765

**ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS:**

Title: ( ) Change ( ) Addition  
Name:  
Address:  
City-St-Zip:

I hereby certify that the information supplied with this filing does not qualify for the 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 electronic 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 above, or on an attachment with an address, with all other like empowered.

SIGNATURE: DAMON D. THORNTON

P

01/08/2004

\_\_\_\_\_ Electronic Signature of Signing Officer or Director

\_\_\_\_\_ Date