


**2005 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Jan 07, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # P02000036474</b> 1. Entity Name MCGILVRAY DENTAL, P.A.	
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Principal Place of Business 6029 N 9TH AVE PENSACOLA, FL 32504	Mailing Address 6029 N 9TH AVE PENSACOLA, FL 32504
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**DO NOT WRITE IN THIS SPACE**



01042005 No Chg-P CR2E034 (10/03)

4. FEI Number 01-0670135	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  MCGILVRAY, JOHN M 6029 N 9TH AVE PENSACOLA, FL 32504
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**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 reinstalling) DATE \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable

<b>FILE NOW!!! FEE IS \$150.00</b> <b>After May 1, 2005 Fee will be \$550.00</b>	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be</b> <b>Added to Fees</b>
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D MCGILVRAY, JOHN M 6029 N 9TH AVE PENSACOLA, FL 32504
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01/07/05-00034-010 150.00

**DO NOT WRITE  
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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: John M. McGilvray DMD 1-4-2005 850-476-5034  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #