

**2007 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Apr 25, 2007 08:00 A
Secretary of State

DOCUMENT # P02000107967 1. Entity Name FREEPORT MEDICAL CLINIC, P.A.	
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Principal Place of Business HIGHWAY 20 FREEPORT, FL 32439	Mailing Address P.O. BOX 289 FREEPORT, FL 32439
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DO NOT WRITE IN THIS SPACE

	
04192007 No Chg-P CR2E034 (11/05)	
4. FEI Number 51-0430172	Applied For Not Applicable
5. Certificate of Status Desired ☐	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent HELMICH, KEVIN M 4481 LEGENDARY DRIVE SUITE 200 DESTIN, FL 32541
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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, 2007 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. ☐ \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D IGNASIAK, ROBERT L M.D. PO BOX 289 FREEPORT, FL 32439
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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: <i>Robert L Ignasiak</i> Robert L Ignasiak	4/19/07 850 534 0173
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR	Date Daytime Phone #