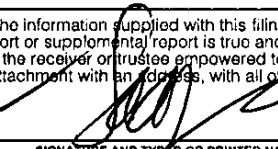


2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 26, 2007 08:00 AM
Secretary of State

| | | | | | |
|--|---|---------------------|---|---|--|
| DOCUMENT # P03000033991 1. Entity Name SAAD MIRZA, M.D., P.A. | | | |  | |
| Principal Place of Business 2297 N UNIVERSITY DR PEMBROKE PINES, FL 33024 | | | Mailing Address 2297 N UNIVERSITY DR PEMBROKE PINES, FL 33024 | | |
| 2. Principal Place of Business - No P.O. Box # | | 3. Mailing Address | | | |
| Suite, Apt. #, etc. | | Suite, Apt. #, etc. | | | |
| City & State | | City & State | | 4. FEI Number 16-1658734 | |
| Zip | | Country | | 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required | |
| 6. Name and Address of Current Registered Agent MIRZA, SAAD MD 16132 NW 13TH STREET PEMBROKE PINES, FL 33028 | | | | 7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code | |
| 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 reinstating) DATE _____ | | | | | |
| FILE NOW!!! FEE IS \$150.00 After May 1, 2007 Fee will be \$550.00 | | | 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees | | |
| 10. OFFICERS AND DIRECTORS | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | D MIRZA, SAAD MD 2297 N UNIVERSITY DR PEMBROKE PINES, FL 33024 | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition U00000605630 01/30/07-80042-018 150.00 | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Delete | | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
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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:  | | | Saad Mirza, M.D. | | |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR | | | Date 1/22/07 Daytime Phone # 954-322-0600 | | |