

# 2005 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED

Feb 07, 2005 08:00 AM  
Secretary of State

DOCUMENT # P03000146799

1. Entity Name

WEST MARION FAMILY MEDICINE, P.A.



Principal Place of Business

4600 SW 46TH CT BLDG 200 STE 160  
OCA LA FL 34474

Mailing Address

1870 ALOMA AVE STE 240  
WINTER PARK FL 32789

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country



1st MOORE

CR2E034 (10/04)

4. FEI Number

03-0534695

Applied For

Not Applicable

5. Certificate of Status Desired



\$8.75 Additional  
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

HOFMEISTER, FRANK CPA  
1870 ALOMA AVE STE 240  
WINTER PARK FL 32789

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

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, 2005 Fee Will Be \$550.00**  
**Make Check Payable to Florida Department of State**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

\$5.00 May Be  
Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE P ☐ Delete  
NAME ROWLEY, MICHAEL MD  
STREET ADDRESS 829 SE 36TH LANE  
CITY- ST- ZIP Ocala FL 34471

☐ Change ☐ Addition  
U00000219365  
02/08/05-80025-015 158.75

TITLE ST ☐ Delete  
NAME WALKER, STEPHANIE MD  
STREET ADDRESS 829 SE 36TH LANE  
CITY- ST- ZIP Ocala FL 34471

☐ Change ☐ Addition

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY- ST- ZIP

☐ Change ☐ Addition

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY- ST- ZIP

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CITY- ST- ZIP

☐ Change ☐ Addition

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY- ST- ZIP

☐ Change ☐ Addition

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: *Stephanie Walker MD* *Stephanie Walker MD* 2/2/05 (352) 873-6044  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #