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	Mailing Address
4600 SW 46TH CT BLDG 200 STE 160 OCALA FL 34474	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

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

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 ______________________________
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

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

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

U00000219365
02/08/05-80025-015 158.75

(Six blocks: TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP, each with ☐ Change ☐ Addition — blank.)

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