


2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 18, 2007 08:00 AM
Secretary of State

DOCUMENT # P04000040357 1. Entity Name GERIATRIC INSTITUTE OF NAPLES INC.					
Principal Place of Business GULF COAST MEDICAL ARTS CENTER 1890 SW HEALTH PKWY, STE 1C NAPLES, FL 34109			Mailing Address GULF COAST MEDICAL ARTS CENTER 1890 SW HEALTH PKWY, STE 1C NAPLES, FL 34109		
2. Principal Place of Business - No P.O. Box # Suite, Apt. #, etc.		3. Mailing Address Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country	4. FEI Number 34-1982977	
5. Certificate of Status Desired <input type="checkbox"/>				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent BOLLA, LEELA R 5995 10TH AVE SW NAPLES, FL 34116				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 <input type="checkbox"/> Delete BOLLA, LEELA R 5995 10TH AVE SW NAPLES, FL 34116		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: _____			4/16/07 Date Daytime Phone: #		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR					