


# 2007 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Jan 10, 2007 8:00 am**  
**Secretary of State**

01-10-2007 90047 017 \*\*\*150.00

<b>DOCUMENT # P05000081926</b>		
1. Entity Name <b>SUSAN F. WILLIAMS, M.D., P.A.</b>		

Principal Place of Business <b>201 BEENEY RD SE PORT CHARLOTTE, FL 33952-9701 US</b>	Mailing Address <b>201 BEENEY RD SE PORT CHARLOTTE, FL 33952-9701 US</b>
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2. Principal Place of Business - No P.O. Box # <b>17928 Toledo Blade Blvd.</b>	3. Mailing Address <b>17928 Toledo Blade Blvd.</b>
Suite, Apt. #, etc.	Suite, Apt. #, etc.

01072007 Chg-P CR2E034 (12/06)

City & State <b>Port Charlotte, FL</b>	City & State <b>Port Charlotte, FL</b>
Zip <b>33948</b>	Zip <b>33948</b>
Country <b>USA</b>	Country <b>USA</b>

4. FEI Number  
**20-2939989**

Applied For  
☐ Not Applicable

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent <b>WILLIAMS, SUSAN F M.D. 201 BEENEY RD SE PORT CHARLOTTE, FL 33952-9701</b>	
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7. Name and Address of New Registered Agent	
Name <b>Williams, Susan F M.D.</b>	
Street Address (P.O. Box Number is Not Acceptable) <b>17928 Toledo-Blade Blvd.</b>	
City <b>Port Charlotte</b>	FL Zip Code <b>33948</b>

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  **Susan F. Williams M.D.** **1/08/07**  
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

<b>FILE NOW!!! FEE IS \$150.00 After May 1, 2007 Fee will be \$550.00</b>	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b>
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>P WILLIAMS, SUSAN F M.D. 201 BEENEY RD SE PORT CHARLOTTE, FL 339529701</b> <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>P Williams, Susan F M.D. 17928 Toledo Blade Blvd Port Charlotte, FL 33948</b> <input checked="" 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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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

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:  **Susan F. Williams, M.D.** **1/08/07** **941 743 7337**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #