
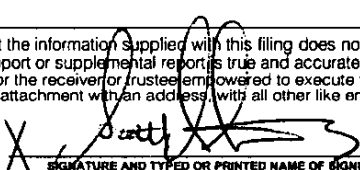


2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 28, 2006 8:00 am
Secretary of State

04-28-2006 90146 036 ***150.00

| | | | | | | |
|--|--|---------|--|---|---|--|
| DOCUMENT # P05000102573 1. Entity Name COASTAL SURGERY ASSOCIATES, P.A. | | | |  | | |
| Principal Place of Business 5741 BEE RIDGE ROAD SUITE 570 SARASOTA, FL 34233 | | | Mailing Address 99 NESBIT STREET PUNTA GORDA, FL 33950 | | | |
| 2. Principal Place of Business Suite, Apt. #, etc. | | | 3. Mailing Address Suite, Apt. #, etc. | | | |
| City & State | | | City & State | | | |
| Zip | | Country | | Zip | | |
| Country | | Country | | 4. FEI Number 20-3197142 | | |
| 5. Certificate of Status Desired <input type="checkbox"/> | | | | Applied For <input type="checkbox"/> Not Applicable | | |
| 6. Name and Address of Current Registered Agent HOLMES, DAVID A ESQ 99 NESBIT STREET PUNTA GORDA, FL 33950 | | | | 7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> FL Zip Code </div> | | |
| 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, 2006 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,P STEVENS, SCOTT B M.D. 5741 BEE RIDGE ROAD, SUITE 570 SARASOTA, FL 34233 | | <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 | S,T STEVENS, SCOTT B M.D. 5741 BEE RIDGE ROAD, SUITE 570 SARASOTA, FL 34233 | | <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 | [Empty] | | <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 | [Empty] | | <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 | [Empty] | | <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 | [Empty] | | <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 reports 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:  | | | 4/5/06 | | | |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR | | | 941-377-4877 | | | |