

**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Mar 26, 2004 08:00 AM
Secretary of State

DOCUMENT # P93000002112

1. Entity Name
UROLOGY HEALTH CENTER, INC.



Principal Place of Business
**5652 MEADOW LANE
NEW PORT RICHEY, FL 34652 US**

Mailing Address
**5652 MEADOW LANE
NEW PORT RICHEY, FL 34652 US**



03192004 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number
59-3174239

Applied For
☐ Not Applicable

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

6. Name and Address of Current Registered Agent

**BEHAR, RAYMOND J
5652 MEADOW LN
NEW PORT RICHEY, FL 34652**

**DO NOT WRITE
IN THIS SPACE**

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, 2004 Fee will be \$550.00**

9. Election Campaign Financing
Trust Fund Contribution. ☐ **\$5.00** May Be
Added to Fees

10. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**DCP
CHOVNICK, STANLEY D
5652 MEADOW LANE
NEW PORT RICHEY, FL**

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**D
BEHAR, RAYMOND J
5652 MEADOW LANE
NEW PORT RICHEY, FL**

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**D
SHARKEY, JERROLD J
5652 MEADOW LANE
NEW PORT RICHEY, FL**

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Stanley Chovnick, M.D.

Date

Daytime Phone #

3/22/04 727.842.956