

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

PROFIT
CORPORATION
ANNUAL REPORT
1996



FLORIDA DEPARTMENT OF STATE
Sandra B. Mathias
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **P93000004447 (7)**

1. Corporation Name

ATLANTIC FAMILY MEDICAL CENTER, P.A.

Principal Place of Business

**13155 ATLANTIC BLVD.
JACKSONVILLE FL 32225
US**

Mailing Address

**13155 ATLANTIC BLVD.
JACKSONVILLE FL 32225
US**



2. Principal Place of Business

2a. Mailing Address

21

26

Suite, Apt. #, etc.

Suite, Apt. #, etc.

22

27

City & State

City & State

23

28

Zip

Country

Zip

Country

24

25

29

30

9. Name and Address of Current Registered Agent

**LEPRELL, SAMUEL L
SUITE 1500
1301 GULF LIFE DR.
JACKSONVILLE FL 32207**

3. Date Incorporated or Qualified

01/15/1993

3a. Date of Last Report

05/01/1995

4. FEI Number

59-3160237

Applied For

Not Applicable

5. Certificate of Status Desired

☐

**\$8.75 Additional
Fee Required**

6. Election Campaign Financing
Trust Fund Contribution

☐

**\$5.00 May Be
Added to Fees**

8. This corporation has liability for intangible tax under s. 199.032,
Florida Statutes.

☒ Yes

☐ No

10. Name and Address of New Registered Agent

81. Name

82. Street Address (P.O. Box Number is Not Acceptable)

83.

84. City

FL

85. Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1502, Florida Statutes, I, the above named corporation, submit this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with and accept the provisions of Section 607.0505, Florida Statutes.

SIGNATURE

Signature of person or persons authorized to execute this report

Signature of New Registered Agent (if different from above)

DATE

12. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY, ST, ZIP
TITLE
NAME
STREET ADDRESS
CITY, ST, ZIP
TITLE
NAME
STREET ADDRESS
CITY, ST, ZIP
TITLE
NAME
STREET ADDRESS
CITY, ST, ZIP
TITLE
NAME
STREET ADDRESS
CITY, ST, ZIP
TITLE
NAME
STREET ADDRESS
CITY, ST, ZIP

**DPST
SILVERBERG, STEPHEN L MD
13155 ATLANTIC BLVD.
JACKSONVILLE FL**

☐ DELETE

☐ DELETE

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☐ DELETE

13.

1. TITLE
1. NAME
1. STREET ADDRESS
1. CITY, ST, ZIP
2. TITLE
2. NAME
2. STREET ADDRESS
2. CITY, ST, ZIP
3. TITLE
3. NAME
3. STREET ADDRESS
3. CITY, ST, ZIP
4. TITLE
4. NAME
4. STREET ADDRESS
4. CITY, ST, ZIP
5. TITLE
5. NAME
5. STREET ADDRESS
5. CITY, ST, ZIP
6. TITLE
6. NAME
6. STREET ADDRESS
6. CITY, ST, ZIP

ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

☐ Change ☐ Addition

☐ Change ☐ Addition

☐ Change ☐ Addition

☐ Change ☐ Addition

☐ Change ☐ Addition

☐ Change ☐ Addition

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.04(3)(k), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 a receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes, and that my name appears in Block 12 or Block 13. I changed or changed with an address.

SIGNATURE:

Stepen L. Silverberg, M.D.

03/28/96

904-221-2222

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

DATE

PHONE NUMBER

CR2E034 (12/95)