


**2006 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
May 01, 2006 08:00 AM
Secretary of State

DOCUMENT # P93000014711 1. Entity Name ISLAND FACIAL PLASTIC AND ENT SURGERY, P.A.	
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Principal Place of Business 9981 HEALTHPARK CIR SUITE 259 FT MYERS, FL 33908	Mailing Address 9981 HEALTHPARK CIR SUITE 259 FT MYERS, FL 33908
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04192006 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number 65-0389794	Applied For Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
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8. Name and Address of Current Registered Agent DAVIS, J BERT MD 9981 HEALTHPARK CIR SUITE 259 FT MYERS, FL 33908

**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, 2006 Fee will be \$550.00

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

000000548119
05/12/06-80051-019 150.00

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD DAVIS, J BERT MD 9981 HEALTHPARK CIR SUITE 259 FT MYERS, FL 33908
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IN THIS SPACE**

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: **J BERT DAVIS MD** **JBERT DAVIS MD** **4-26-06** **239-481-9211**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #