FILE NOW: FILING FEE AFTER MAY 1 IS $225.00

CORPORATION ANNUAL REPORT **1995**

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

APPROVED AND FILED

95 MAR -6 AM 9:31

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P93000035893 (5)

1. Corporation Name
NORMANDY HEALTH SERVICES, INC.

Principal Place of Business	Mailing Address
900 - 71ST ST. MIAMI BCH. FL 33141 US	900 - 71ST ST. MIAMI BCH. FL 33141 US

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified: 05/17/1993
3a. Date of Last Report: 04/13/1994

2. Principal Place of Business (21):
2a. Mailing Address (26):
Suite, Apt. #, etc. (22):
Suite, Apt. #, etc. (27):
City & State (23):
City & State (28):
Zip (24): Country (25): Zip (29): Country (30):

4. FEI Number: 65-0390697 ☐ 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. The corporation has liability for intangible tax under S. 199.032, Florida Statutes ☒ Yes ☐ No

9. Name and Address of Current Registered Agent

WASMER, JOSE M.D.
747 PONCE DE LEON BLVD.
SUITE 700
CORAL GABLES FL 33134

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 607.1508, Florida Statutes, the above-named corporation submits 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 obligations of, Section 607.0505, Florida Statutes.

SIGNATURE (Typed or printed name of registered agent and title if applicable) NOTE: Registered Agent Signature required when reinstating DATE

12. OFFICERS AND DIRECTORS	13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12
TITLE PD NAME WASMER, JOSE M.D. STREET ADDRESS 747 PONCE DE LEON BLVD., #700 CITY-ST-ZIP CORAL GABLES FL 33134	11 TITLE ☐ Change ☐ Addition 12 NAME 13 STREET ADDRESS 14 CITY-ST-ZIP
TITLE VD NAME MAGGIOLO, LUIS F M.D. STREET ADDRESS 747 PONCE DE LEON BLVD., #700 CITY-ST-ZIP CORAL GABLES FL 33134	21 TITLE ☐ Change ☐ Addition 22 NAME 23 STREET ADDRESS 24 CITY-ST-ZIP
TITLE TD NAME MURCIANO, ENRIQUE M.D. STREET ADDRESS P.O. BOX 143227 N/A CITY-ST-ZIP CORAL GABLES FL 33143	31 TITLE ☐ Change ☐ Addition 32 NAME 33 STREET ADDRESS 34 CITY-ST-ZIP
TITLE SD NAME MURCIANO, ALFREDO STREET ADDRESS 900 71ST ST. CITY-ST-ZIP MIAMI BEACH FL 33141	41 TITLE ☐ Change ☐ Addition 42 NAME 43 STREET ADDRESS 44 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	51 TITLE ☐ Change ☐ Addition 52 NAME 53 STREET ADDRESS 54 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	61 TITLE ☐ Change ☐ Addition 62 NAME 63 STREET ADDRESS 64 CITY-ST-ZIP

14. I hereby certify that the information supplied with this filing is true and 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 12 or Block 13 (if changed), on the report or supplement with an address.

SIGNATURE: X (SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR) 2-22-95 (Date) (305) 867-1243 (Daytime Phone #)

PRESIDENT

0191060 CP