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2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 29, 2004 8:00 am
Secretary of State
04-29-2004 90210 038 ***158.75

DOCUMENT # P93000045882

1. Entity Name
MCLEOD ORTHOPEDIC CLINIC, P.A.

Principal Place of Business	Mailing Address
504 PALMETTO ST. NEW SMYRNA BEACH, FL 32168 US	504 PALMETTO ST. NEW SMYRNA BEACH, FL 32168 US

2. Principal Place of Business	3. Mailing Address
McLeod Orthopedic Clinic	504 Palmetto St.
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: New Smyrna Bch, FL	City & State:
Zip: 32168 Country: USA	Zip: Country:

04272004 Chg-P CR2E034 (10/03)

4. FEI Number: 59-3188715 — Applied For / Not Applicable

5. Certificate of Status Desired ☒ $8.75 Additional Fee Required

6. Name and Address of Current Registered Agent
MCLEOD, WILLIAM P M.D.
504 PALMETTO ST.
NEW SMYRNA BEACH, FL 32168

7. Name and Address of New Registered Agent
Name
Street Address (P.O. Box Number is Not Acceptable)
City FL Zip Code

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	D	☐ Delete
NAME	MCLEOD, WILLIAM P M.D.	
STREET ADDRESS	504 PALMETTO ST.	
CITY-ST-ZIP	NEW SMYRNA BEACH, FL 32168	
TITLE		☐ Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Delete
NAME		
STREET ADDRESS		
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NAME		
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CITY-ST-ZIP		
TITLE		☐ Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE		☐ Change ☐ Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Change ☐ Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
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NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Change ☐ Addition
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: WPMcLeod MD William P. McLeod MD. 4/27/04 386-424-9601
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #