


**2006 FOR PROFIT CORPORATION
ANNUAL REPORT**

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

| | |
|---|---|
| DOCUMENT # P93000078415 1. Entity Name NORTH FLORIDA EYE INSTITUTE, P.A. |  |
|---|---|

| | |
|---|---|
| Principal Place of Business 3009 4TH ST MARIANNA, FL 32446 US | Mailing Address 3009 4TH ST MARIANNA, FL 32446 US |
|---|---|



01032006 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

| | |
|---|--|
| 4. FEI Number 65-0449421 | Applied For <input type="checkbox"/> Not Applicable |
| 5. Certificate of Status Desired <input type="checkbox"/> | \$8.75 Additional Fee Required |

| |
|--|
| 6. Name and Address of Current Registered Agent ROSEN, SEYMOUR R MD 3009 4TH ST MARIANNA, FL 32446 |
|--|

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 _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS \$150.00
After May 1, 2006 Fee will be \$550.00

| | |
|--|------------------------------------|
| 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> | \$5.00 May Be Added to Fees |
|--|------------------------------------|

| 10. OFFICERS AND DIRECTORS | |
|--|---|
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | D ROSEN, SEYMOUR R MD 3009 4TH ST MARIANNA, FL |
| 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 | |

1100000452425
03/01/06-R0025-024 150.00

DO NOT WRITE 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: Seymour R. Rosen, MD Seymour R. Rosen MD. 3/1/06 (850) 526 3937
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #