

# 2005 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED

Feb 14, 2005 08:00 AM  
Secretary of State

DOCUMENT # P94000003641

1. Entity Name

GOLDEN ISLES ANESTHESIA ASSOCIATES, P.A.



Principal Place of Business  
607 OLLEANDER DRIVE  
HALLANDALE FL 33009

Mailing Address  
607 OLLEANDER DRIVE  
HALLANDALE FL 33009

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number 65-0546599

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional  
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

VANDLING, THEODORE F  
607 OLLEANDER DRIVE  
HALLANDALE FL 33009

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, 2005 Fee Will Be \$550.00

Make Check Payable to Florida Department of State

9. Election Campaign Financing  
Trust Fund Contribution. ☐

\$5.00 May Be  
Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE  
NAME  
STREET ADDRESS  
CITY - ST - ZIP  
DP  
VANDLING, THEODORE F  
607 OLLEANDER DRIVE  
HALLANDALE FL 33009 ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY - ST - ZIP  
U00000228019  
02/14/05-80021-020 150.00 ☐ Change ☐ Addition

TITLE  
NAME  
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VANDLING, VELDA  
607 OLLEANDER DRIVE  
HALLANDALE FL 33009 ☐ Delete

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12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

2-8-05

354-817-6612

Date

Daytime Phone #