

**2005 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Apr 30, 2005 08:00 AM
Secretary of State

DOCUMENT # P94000031218 1. Entity Name CARDIOVASCULAR SPECIALISTS, P.A.	
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Principal Place of Business 305 N MANGOUSTINE AVE STE 200 SANFORD, FL 32771 US	Mailing Address 305 N MANGOUSTINE AVE STE 200 SANFORD, FL 32771 US
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03022005 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-3238016	Applied For Not Applicable
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5. Certificate of Status Desired ☐	\$8.75 Additional Fee Required
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6. Name and Address of Current Registered Agent CHIDA, MUBEEN H 305 N. MANGOUSTINE AVE STE 102 SANFORD, FL 32771
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**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 _____ (NOTE: Registered Agent signature required when reinstalling) DATE _____

**FILE NOW!!! FEE IS \$150.00
After May 1, 2005 Fee will be \$550.00**

9. Election Campaign Financing Trust Fund Contribution. ☐	\$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	P CHIDA, MUBEEN H 305 N. MANGOUSTINE AVE SANFORD, FL 32771
TITLE NAME STREET ADDRESS CITY - ST - ZIP	S SHAHNAZ, CHIDA MD 305 N. MANGOUSTINE AVE SANFORD, FL 32771
TITLE NAME STREET ADDRESS CITY - ST - ZIP	
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04/30/05-80037-014 150.00

**DO NOT WRITE
IN THIS SPACE**

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: SHAHNAZ CHIDA M.D. 4-27-05 407 321-1415
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #