2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
May 12, 2004 8:00 am
Secretary of State
05-12-2004 90203 008 ***500.00

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1. Entity Name
YORKSHIRE MENTAL HEALTH ENTERPRISES, P.A.

Principal Place of Business	Mailing Address
595 W. GRANADA BLVD. SUITE 2E ORMOND BEACH, FL 32174	595 W. GRANADA BLVD. SUITE 2E ORMOND BEACH, FL 32174

DO NOT WRITE IN THIS SPACE

01202004 No Chg-P CR2E034 (10/03)

4. FEI Number
59-3249267
☐ Applied For
☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

RAIMONDO, LOUIS J
595 W. GRANADA BLVD.
SUITE 2E
ORMOND BEACH, FL 32174

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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, 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
NAME	RAIMONDO, LOUIS J
STREET ADDRESS	103 SAND DUNES DRIVE
CITY-ST-ZIP	ORMOND BY THE SEA, FL 32176
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
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NAME	
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CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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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)(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: Louis Raimondo MD 5-4-04
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

LOUIS RAIMONDO MD 386-672-4222