

**2006 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Apr 19, 2006 08:00 AM**  
**Secretary of State**

**DOCUMENT # P94000069825**

1. Entity Name  
**SOUTH BROWARD MRI CENTER, INC.**



Principal Place of Business

**4700-D SHERIDAN ST.  
HOLLYWOOD, FL 33021**

Mailing Address

**4700-D SHERIDAN ST.  
HOLLYWOOD, FL 33021**

**DO NOT WRITE IN THIS SPACE**



03092006 No Chg-P CR2E034 (11/05)

4. FEI Number  
**65-0520760**

Applied For  
Not Applicable

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

6. Name and Address of Current Registered Agent

**SHICK, HERBERT L M.D.  
4700-D SHERIDAN STREET  
HOLLYWOOD, FL 33021**

**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

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, 2006 Fee will be \$550.00**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

**\$5.00** May Be  
Added to Fees

001100518908  
05/02/06-80031-020 158.75

10. OFFICERS AND DIRECTORS

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
**D  
SHICK, HERBERT L M.D.  
% 4700-D SHERIDAN ST.  
HOLLYWOOD, FL 33021**

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

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CITY-ST-ZIP

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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, but not a name, as required.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

**HERBERT L. SHICK, M.D.**

**APR 17 2006**

**954-962-4700**