


2008 FOR PROFIT CORPORATION ANNUAL REPORT


FILED
Mar 17, 2008 08:00 A
Secretary of State

DOCUMENT # P94000081448
 1. Entity Name
 CENTRAL FLORIDA MEDICAL CARE, P.A.



Principal Place of Business 29320 USHWY 27 LEESBURG, FL 34748 US	Mailing Address 29320 US HWY 27 LEESBURG, FL 34748 US
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DO NOT WRITE IN THIS SPACE



03052008 No Chg-P CR2E034 (11/05)

4. FEI Number 59-3276410	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent

LICHINTGER, DAVID R.
 29320 US HWY 27
 LEESBURG, FL 34748

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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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00
After May 1, 2008 Fee will be \$550.00

9. Election Campaign Financing Trust Fund Contribution. **\$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P LICHITINGER, DAVID R. 29320 US HWY 27 LEESBURG, FL
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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: *David Lichintger*
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date: *3/13/08* Daytime Phone #: *352-360-0400*