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Mar 06, 1999 8:00 am
Secretary of State

03-06-1999 90016 009 ***150.00

PROFIT
CORPORATION
ANNUAL REPORT
1999



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P95000024001

1. Corporation Name
PATHOLOGY MANAGEMENT CONSULTANTS, P.A.

Principal Place of Business

Mailing Address

**AVENTURA HOSPITAL
20900 BISCAYNE BLVD.
AVENTURA FL 33180
US**

**AVENTURA HOSPITAL
20900 BISCAYNE BLVD
AVENTURA FL 33180
US**

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified

03/20/1995

4. FEI Number

65-0558664

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution ☐

\$5.00 May Be
Added to Fees

8. This corporation owes the current year Intangible
Personal Property Tax. ☒ Yes ☐ No

2. Principal Place of Business

2a. Mailing Address

21 Suite, Apt. #, etc.

26 Suite, Apt. #, etc.

22 City & State

27 City & State

23 Zip

Country

28 Zip

Country

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

**B & C CORPORATE SERVICES, INC.
201 S BISCAYNE BLVD
SUITE 3000
MIAMI FL 33131**

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

TITLE **D** ☐ DELETE

NAME **VILLA, LUIS JR.**

STREET ADDRESS **CEDARS MEDICAL CENTER 1400 NW 12 AVE**

CITY-ST-ZIP **MIAMI FL 33136**

TITLE **D** ☐ DELETE

NAME **MORJAIM, ISADORO**

STREET ADDRESS **CEDARS MEDICAL CENTER 1400 NW 12 AVE**

CITY-ST-ZIP **MIAMI FL 33136**

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

1.1 TITLE

1.2 NAME

1.3 STREET ADDRESS

1.4 CITY-ST-ZIP

2.1 TITLE

2.2 NAME

2.3 STREET ADDRESS

2.4 CITY-ST-ZIP

3.1 TITLE

3.2 NAME

3.3 STREET ADDRESS

3.4 CITY-ST-ZIP

4.1 TITLE

4.2 NAME

4.3 STREET ADDRESS

4.4 CITY-ST-ZIP

5.1 TITLE

5.2 NAME

5.3 STREET ADDRESS

5.4 CITY-ST-ZIP

6.1 TITLE

6.2 NAME

6.3 STREET ADDRESS

6.4 CITY-ST-ZIP

14. 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 annual report or supplemental annual 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 12 or Block 13 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

2/19/99 **201-8548080**

Date

Daytime Phone #

CR2E034 (11/98)