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# Secretary of State

PROFIT CORPORATION ANNUAL REPORT

**1997**

FLORIDA DEPARTMENT OF STATE
**Sandra B. Mortham**
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **P95000035256 (3)**

1. Corporation Name
**SHORELINE MEDICAL GROUP, P.A.**

| Principal Place of Business | Mailing Address |
|---|---|
| P O BOX 1065<br>14 POINT MALL ISLAND DR<br>EASTPOINT FL 32328 | P O BOX 1065<br>14 POINT MALL ISLAND DR<br>EASTPOINT FL 32328-1065 |

3. Date Incorporated or Qualified: 05/05/1995
3a. Date of Last Report: 02/28/1996

2. Principal Place of Business (21): 419 Baltzell Ave.
Suite, Apt. #, etc. (22):
City & State (23): Port St. Joe, FL
Zip (24): 32456 Country (25):

2a. Mailing Address (26): 419 Baltzell Ave.
Suite, Apt. #, etc. (27):
City & State (28): Port St. Joe, FL
Zip (29): 32456 Country (30):

4. FEI Number: 59-3312087 ☐ 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 has liability for intangible tax under s. 199.032, Florida Statutes ☒ Yes ☐ No

**9. Name and Address of Current Registered Agent**

CURRY, THOMAS L
14 PONT MALL
ISLAND DR
EASTPOINT FL 32328

**10. Name and Address of New Registered Agent**

81 Name: Curry, Thomas L.
82 Street Address (P.O. Box Number is Not Acceptable): 419 Baltzell Ave.
83:
84 City: Port St Joe FL 85 Zip Code: 32456

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] M.D. Thomas L. Curry, M.D. 2/28/97
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 | 1.1 TITLE | D | ☒ Change ☐ Addition |
| NAME | CURRY, THOMAS L | | 1.2 NAME | Curry, Thomas L. | |
| STREET ADDRESS | HC 1 BOX 326 | | 1.3 STREET ADDRESS | 719½ Windward St. | |
| CITY-ST-ZIP | PORT ST JOE FL 32456 | | 1.4 CITY-ST-ZIP | Port St. Joe, FL 32456 | |
| TITLE | D | ☐ DELETE | 2.1 TITLE | D | ☒ Change ☐ Addition |
| NAME | CURRY, ELIZABETH F | | 2.2 NAME | Curry, Elizabeth F. | |
| STREET ADDRESS | HC 1 BOX 326 | | 2.3 STREET ADDRESS | 719½ Windward St. | |
| CITY-ST-ZIP | PORT ST JOE FL 32456 | | 2.4 CITY-ST-ZIP | Port St. Joe, FL 32456 | |
| TITLE | | ☐ DELETE | 3.1 TITLE | | ☐ Change ☐ Addition |
| NAME | | | 3.2 NAME | | |
| STREET ADDRESS | | | 3.3 STREET ADDRESS | | |
| CITY-ST-ZIP | | | 3.4 CITY-ST-ZIP | | |
| TITLE | | ☐ DELETE | 4.1 TITLE | | ☐ Change ☐ Addition |
| NAME | | | 4.2 NAME | | |
| STREET ADDRESS | | | 4.3 STREET ADDRESS | | |
| CITY-ST-ZIP | | | 4.4 CITY-ST-ZIP | | |
| TITLE | | ☐ DELETE | 5.1 TITLE | | ☐ Change ☐ Addition |
| NAME | | | 5.2 NAME | | |
| STREET ADDRESS | | | 5.3 STREET ADDRESS | | |
| CITY-ST-ZIP | | | 5.4 CITY-ST-ZIP | | |
| TITLE | | ☐ DELETE | 6.1 TITLE | | ☐ Change ☐ Addition |
| NAME | | | 6.2 NAME | | |
| STREET ADDRESS | | | 6.3 STREET ADDRESS | | |
| CITY-ST-ZIP | | | 6.4 CITY-ST-ZIP | | |

CR2E034 (9/96)

14. I do 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.

**SIGNATURE:** [signature] M.D. Thomas L. Curry, M.D. 2/28/97 (904) 229-8010
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #