


**2005 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Apr 14, 2005 08:00 AM
Secretary of State

DOCUMENT # P95000040727 1. Entity Name SEBRING PEDIATRICS, P.A.	
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Principal Place of Business 1004 SE LAKE VIEW DRIVE SEBRING, FL 33870 US	Mailing Address 1004 SE LAKE VIEW DR SEBRING, FL 33870 US
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01052005 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-3314618	Applied For Not Applicable
5. Certificate of Status Desired <input checked="" type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent MCCOLLUM, JAMES F 129 SO. COMMERCE AVENUE SEBRING, FL 33870	DO NOT WRITE IN THIS SPACE
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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 _____
Signature, typed or printed name of registered agent and file if applicable.

**FILE NOW!!! FEE IS \$150.00
After May 1, 2005 Fee will be \$550.00**

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

000000305927
04/14/05-80107-001 158.75

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D SONNI, RAJESWARI M.D. 1104 SE LAKEVIEW DRIVE SEBRING, FL 33870
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	

**DO NOT WRITE
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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: Rajeswari Sonni RAJESWARI SONNI M.D. 03 23 05 (883) 452-0566
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #