

FILE NOW: FILING FEE AFTER MAY 1 IS \$225.00

PROFIT  
CORPORATION,  
ANNUAL REPORT  
1996



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

DOCUMENT # P95000077070 (7)

1. Corporation Name

POLK COUNTY ANESTHESIA, P.A.

Principal Place of Business

B.M.H. - DEPT. OF ANESTHESIOLOGY  
1239 EAST MAIN ST.  
BARTOW FL 33830

Mailing Address

B.M.H. - DEPT. OF ANESTHESIOLOGY  
1239 EAST MAIN ST.  
BARTOW FL 33830



3. Date Incorporated or Qualified

10/01/1995

3a. Date of Last Report

2. Principal Place of Business

21

Suite, Apt. #, etc.

22

City & State

23

Zip

Country

24

2a. Mailing Address

26

Suite, Apt. #, etc.

27

City & State

28

Zip

Country

29

30

9. Name and Address of Current Registered Agent

SALEM, MARY GED M.D.  
B.M.H. - DEPT. OF ANESTHESIOLOGY  
1239 EAST MAIN ST.  
BARTOW FL 33830

4. FEI Number

59-333 9231

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

10. Name and Address of New Registered Agent

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 or director (check one)

(NOTE: Registered Agent Signature required when registering)

(NOTE: Signature required when changing agent)

12. OFFICERS AND DIRECTORS

TITLE

NAME

STREET ADDRESS

CITY - ST - ZIP

D

SALEM, MARY GED M.D.  
1239 EAST MAIN ST.-DEPT. OF ANESTHESIOLOGY  
BARTOW FL 33830

☐ DELETE

TITLE

NAME

STREET ADDRESS

CITY - ST - ZIP

D

WEEKES, ANN MARIE E D.O.  
1239 EAST MAIN ST.-DEPT. OF ANESTHESIOLOGY  
BARTOW FL 33830

☐ DELETE

TITLE

NAME

STREET ADDRESS

CITY - ST - ZIP

☐ DELETE

TITLE

NAME

STREET ADDRESS

CITY - ST - ZIP

☐ DELETE

TITLE

NAME

STREET ADDRESS

CITY - ST - ZIP

☐ DELETE

TITLE

NAME

STREET ADDRESS

CITY - ST - ZIP

☐ DELETE

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE

1.2 NAME

1.3 STREET ADDRESS

1.4 CITY - ST - ZIP

☐ Change

☐ Addition

2.1 TITLE

2.2 NAME

2.3 STREET ADDRESS

2.4 CITY - ST - ZIP

☐ Change

☐ Addition

3.1 TITLE

3.2 NAME

3.3 STREET ADDRESS

3.4 CITY - ST - ZIP

☐ Change

☐ Addition

4.1 TITLE

4.2 NAME

4.3 STREET ADDRESS

4.4 CITY - ST - ZIP

☐ Change

☐ Addition

5.1 TITLE

5.2 NAME

5.3 STREET ADDRESS

5.4 CITY - ST - ZIP

☐ Change

☐ Addition

6.1 TITLE

6.2 NAME

6.3 STREET ADDRESS

6.4 CITY - ST - ZIP

☐ Change

☐ Addition

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\*\*\*200.00

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(b), 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: Mary G. Salem MARY G. SALEM M.D.

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4-26-96

534 7816

CR2E034 (12/95)