

SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER SEPTEMBER 17, 1997.
AMOUNT DUE ON OR BEFORE 9/17/97: \$550 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$750.)

10/2

PROFIT CORPORATION ANNUAL REPORT 1997		FLORIDA DEPARTMENT OF STATE Sandra B. Mortham Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # P95000088031 (6)
1. Corporation Name
FLORIDA PRIMARY MEDICAL HEALTH SERVICE, P.A.

FILED
97 SEP -8 AM 11:26
SECRETARY OF STATE
TALLAHASSEE, FLORIDA



Principal Place of Business ROLLINS COLLEGE 1000 HOLT AVENUE WINTER PARK FL 32789 US	Mailing Address C/O COLLEGIATE HEALTH CARE 800 CONNETTICUT AVE NORWALK CT 06856 US
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DO NOT WRITE IN THIS SPACE

2. Principal Place of Business 21 Suite, Apt. #, etc. 22 City & State 23 Zip 24 Country	2a. Mailing Address 26 Suite, Apt. #, etc. 27 City & State 28 Zip 29 Country	3. Date Incorporated or Qualified 11/16/1995 3a. Date of Last Report 08/01/1996 4. FEI Number 59-3329627 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required 6. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/> \$5.00 May Be Added to Fees 8. This corporation owes or has paid the current year Intangible Personal Property Tax due June 30. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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9. Name and Address of Current Registered Agent NRAI SERVICES, INC. 528 E. PARK AVE. TALLAHASSEE FL 32301	10. Name and Address of New Registered Agent 81 Name 82 Street Address (P.O. Box Number is Not Acceptable) 83 84 City 85 Zip Code FL
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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 NAME STREET ADDRESS CITY-ST-ZIP	DP KAM, JR., FREDERICK A M.D. 800 CONNECTICUT AVENUE NORWALK CT <input type="checkbox"/> DELETE	1.1 TITLE 1.2 NAME 1.3 STREET ADDRESS 1.4 CITY-ST-ZIP	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition zip code for Dr. Kam 06856
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> DELETE	2.1 TITLE 2.2 NAME 2.3 STREET ADDRESS 2.4 CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> DELETE	3.1 TITLE 3.2 NAME 3.3 STREET ADDRESS 3.4 CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> DELETE	4.1 TITLE 4.2 NAME 4.3 STREET ADDRESS 4.4 CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition 100002288981--9 -09/10/97--01040--024 ****165.00 ****165.00
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> DELETE	5.1 TITLE 5.2 NAME 5.3 STREET ADDRESS 5.4 CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> DELETE	6.1 TITLE 6.2 NAME 6.3 STREET ADDRESS 6.4 CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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 _____

CR2E034 (4/97)

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FLORIDA PRIMARY MEDICAL HEALTH SERVICES, P.A.

August 25, 1997

State of Florida
Division of Corporations
Attn: Annual Reports
P.O. Box 6327
Tallahassee, FL 32314

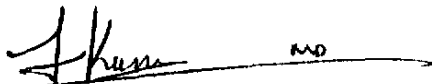
RE: Annual Report and Filing Fee

Dear Sir or Madam:

Enclosed is the annual report and filing fee for Florida Primary Medical Health Services, PA. Upon reviewing the second notice, it was apparent that we had never received the first notice. Therefore, at the direction of a representative at your office, I have enclosed a check for \$165 for this year's annual filing fee.

If you have any questions, please contact my assistant, Alicia Sampath, at 203-851-1793.

Sincerely,

A handwritten signature in dark ink, appearing to read "F. Kam", with a horizontal line extending to the right.

Frederick A. Kam
President

Encl.