FILE NOW: FILING FEE AFTER MAY 1ST IS $550.00

PROFIT CORPORATION ANNUAL REPORT

1999

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

FILED
99 APR -1 AM 9:15
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

0522278

DOCUMENT # **P95000091239**

1. Corporation Name
INPHYNET MANAGED CARE, INC.

Principal Place of Business
1200 S. PINE ISLAND ROAD
SUITE 600
PLANTATION FL 33324

Mailing Address
3000 GALLERIA TOWER
SUITE 1000
BIRMINGHAM AL 35244

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified
11/30/1995

4. FEI Number
65-0622858
[ ] 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
21
Suite, Apt #, etc
22
City & State
23
Zip 24 Country 25

2a. Mailing Address
26
Suite, Apt #, etc.
27
City & State
28
Zip 29 Country 30

9. Name and Address of Current Registered Agent
CORPORATION SERVICE COMPANY
1201 HAYS STREET
TALLAHASSEE FL 32301-2525

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 and title, if applicable — (NOTE: Registered Agent must sign or fax back this form) — Date

12. OFFICERS AND DIRECTORS

TITLE	PDCE	[X] DELETE
NAME	CRAWFORD, E. MAC	
STREET ADDRESS	3000 GALLERIA TOWER, SUITE 1000	
CITY-ST-ZIP	BIRMINGHAM AL 35244	
TITLE	VTD	[X] DELETE
NAME	KNIGHT, HAROLD O JR.	
STREET ADDRESS	3000 GALLERIA TOWER, SUITE 1000	
CITY-ST-ZIP	BIRMINGHAM AL 35244	
TITLE	VSD	[X] DELETE
NAME	THRASHER, TRACY P	
STREET ADDRESS	3000 GALLERIA TOWER, SUITE 1000	
CITY-ST-ZIP	BIRMINGHAM AL 35244	
TITLE	SVPC	[X] DELETE
NAME	PRADO, MARTA	
STREET ADDRESS	1200 S PINE ISLAND RD SUITE 600	
CITY-ST-ZIP	PLANTATION FL 33324	
TITLE		[ ] DELETE
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		[ ] DELETE
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

PD **LUIS MOSQUERA** [ ] Change [X] Add
3000 GALLERIA TOWER, SUITE 1000
BIRMINGHAM, AL 32544

VPSD **SARA J. FINLEY** [ ] Change [X] Add
3000 GALLERIA TOWER, SUITE 1000
BIRMINGHAM, AL 32544

TD **LEISA KIZER** [ ] Change [X] Add
3000 GALLERIA TOWER, SUITE 1000
BIRMINGHAM, AL 32544

[ ] Change [ ] Add

[ ] Change [ ] Add

[ ] Change [ ] Add

[ ] Change [ ] Add

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: Leisa S. Kizer — Leisa S. Kizer — 3/31/99 — 205/733-8996
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034 (11/98)

(2)

ACCOUNT NO. : 072100000032

REFERENCE : 190835 4390339

AUTHORIZATION : Patricia Pizzuto

COST LIMIT : $ 150.00

ORDER DATE : April 1, 1999

ORDER TIME : 3:48 PM

ORDER NO. : 190835-035

CUSTOMER NO: 4390339

CUSTOMER: Ms. Danielle Bayer
Medpartners, Inc.
3000 Galleria Tower
Suite 1000
Birmingham, AL 35244

ANNUAL REPORT FILING

NAME: INPHYNET MANAGED CARE, INC.

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

_____ CERTIFIED COPY
XX PLAIN STAMPED COPY
_____ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: James Guy

EXAMINER'S INITIALS: _____