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AND  
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98 FEB 17 PM 2:33

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA



DO NOT WRITE IN THIS SPACE

<b>* PROFIT CORPORATION ANNUAL REPORT 1998</b>		FLORIDA DEPARTMENT OF STATE <b>Sandra B. Mortham</b> Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # **P96000008902 (4)**

1. Corporation Name

**KAPPA MEDICAL EQUIPMENT, INC.**

Principal Place of Business

**4506 L.B. MCLEOD RD SUITE F  
ORLANDO FL 32811**

Mailing Address

**P.O. BOX 53-6576  
ORLANDO FL 32853-6576**

2. Principal Place of Business

21

Suite, Apt. #, etc.

22

City & State

23

Zip

Country

24

25

2a. Mailing Address

26

Suite, Apt. #, etc.

27

City & State

28

Zip

Country

29

30

9. Name and Address of Current Registered Agent

**GRIGGS, STEPHEN P  
4506 LB MCLEOD RD  
SUITE F  
ORLANDO FL 32811**

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

**32381**

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

**Karen B. Rozar, As Its Agent**

**2-17-98**

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

TITLE **PASD** ☐ DELETE

NAME **GRIGGS, STEPHEN P**

STREET ADDRESS **4506 L.B. MCLEOD RD SUITE F**

CITY-ST-ZIP **ORLANDO FL**

TITLE **STD** ☒ DELETE

NAME **IRISH, REBECCA R**

STREET ADDRESS **4506 L.B. MCLEOD RD SUITE F**

CITY-ST-ZIP **ORLANDO FL**

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

TITLE ☐ DELETE

NAME

STREET ADDRESS

CITY-ST-ZIP

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

1.1 TITLE **D/P** ☒ Change ☐ Addition

1.2 NAME **Stephen P. Griggs**

1.3 STREET ADDRESS

1.4 CITY-ST-ZIP

2.1 TITLE **VP** ☐ Change ☒ Addition

2.2 NAME **Janet L. Ziomek**

2.3 STREET ADDRESS **4506 L.B. Mcleod Rd., Suite F**

2.4 CITY-ST-ZIP **Orlando, FL 32811**

3.1 TITLE **S** ☐ Change ☒ Addition

3.2 NAME **n. Scott Novell**

3.3 STREET ADDRESS **4506 L.B. Mcleod Rd., Suite F**

3.4 CITY-ST-ZIP **Orlando, FL 32811**

4.1 TITLE **D** ☐ Change ☒ Addition

4.2 NAME **Mare Kevin**

4.3 STREET ADDRESS **10065 Red Run Blvd.**

4.4 CITY-ST-ZIP **Owings Mills, MD 21117**

5.1 TITLE **D** ☐ Change ☒ Addition

5.2 NAME **Marshall Elkins**

5.3 STREET ADDRESS **10065 Red Run Blvd.**

5.4 CITY-ST-ZIP **Owings Mills, MD 21117**

6.1 TITLE ☐ Change ☐ Addition

6.2 NAME

6.3 STREET ADDRESS

6.4 CITY-ST-ZIP

**600002432936--3**

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.

SIGNATURE

*[Signature]*

*[Signature]*

CR2E034 (10/97)



ACCOUNT NO. : 072100000032

REFERENCE : 708230 7120726

AUTHORIZATION :

COST LIMIT : \$ 150.00

*Patricia Pignatelli*

ORDER DATE : February 16, 1998

ORDER TIME : 9:36 AM

ORDER NO. : 708230-320

CUSTOMER NO: 7120726

CUSTOMER: Ms. Dawn Anderson  
Rotech Medical Corporation  
Suite F  
4506 L B Mcleod Road  
Orlando, FL 32811

RECEIVED  
98 FEB 17 AM 10:50  
DIVISION OF CORPORATION

ANNUAL REPORT FILING

NAME: KAPPA MEDICAL EQUIPMENT, INC.

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

       CERTIFIED COPY  
XX        PLAIN STAMPED COPY  
       CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Jeanine Glisar

EXAMINER'S INITIALS: \_\_\_\_\_