

2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Feb 06, 2008 8:00 am
Secretary of State

02-06-2008 90030 042 ***150.00

DOCUMENT # P96000018031					
1. Entity Name MORTON PLANT MEASE OUTPATIENT ANESTHESIOLOGY, P.A.					
Principal Place of Business 6600 MADISON STREET NEW PORT RICHEY, FL 34652 US			Mailing Address POBOX 340382 TAMPA, FL 33694-0782		
2. Principal Place of Business - No P.O. Box #		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State		4. FEI Number 65-0664829	
Zip		Country		Applied For Not Applicable	
Zip		Country		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent			7. Name and Address of New Registered Agent		
GUBBINI, PAUL 6600 MADISON STREET NEW PORT RICHEY, FL 34652			Name Street Address (P.O. Box Number is Not Acceptable) City		
			FL Zip Code		
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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>					
FILE NOW!!! FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/>		\$5.00 May Be Added to Fees	
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD GUBBINI, PAUL 6600 MADISON STREET NEW PORT RICHEY, FL 34652	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP DHALIWAL, TEJINDAR 6600 MADISON STREET NEW PORT RICHEY, FL 34652	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V MINNEA, KALRA 6600 MADISON STREET NEW PORT RICHEY, FL 34652	<input checked="" type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete			
12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>					
Date _____ Daytime Phone # _____					