


2005 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
May 23, 2005 08:00 AM
Secretary of State

DOCUMENT # P96000022854	
1. Entity Name LITOWITZ, ORTHODONTIST, D.M.D., P.A.	

Principal Place of Business 6110 S ATLANTIC AVE NEW SMYRNA BEACH, FL 32169	Mailing Address 6110 S ATLANTIC AVE NEW SMYRNA BEACH, FL 32169
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05032005 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number 59-3379309	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent LITOWITZ, ARTHUR N 6110 S ATLANTIC AVE NEW SMYRNA BEACH, FL 32169

DO NOT WRITE IN THIS SPACE

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 _____ (Signature, typed or printed name of registered agent and title if applicable) (NOTE: Registered Agent signature required when relistating) DATE _____

**FILE NOW!!! FEE IS \$550.00
Due by September 7, 2005**

9. Election Campaign Financing
Trust Fund Contribution. ☐ **\$5.00 May Be
Added to Fees**

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P LITOWITZ, ARTHUR N DMD 6110 S ATLANTIC AVE NEW SMYRNA BEACH, FL 32169
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP KIMBL, KIT 6110 S ATLANTIC AVE NEW SMYRNA BEACH, FL 32169
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05/23/05-80002-005 550.00

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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: Arthur N. Litowitz, DMD **ARTHUR N. LITOWITZ, DMD** **5-3-05** **386-424-9352**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #