


# 2005 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Jan 24, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # P96000056143</b>		
1. Entity Name <b>ROSS LIEBERFARB, M.D., P.A.</b>		
Principal Place of Business <b>6759 ROYAL ORCHID CIRCLE DELRAY BEACH, FL 33446 US</b>	Mailing Address <b>6759 ROYAL ORCHID CIRCLE DELRAY BEACH, FL 33446 US</b>	



01202005 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number <b>65-0689095</b>	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75 Additional Fee Required</b>	

**6. Name and Address of Current Registered Agent**

**LIEBERFARB, ROSS MD  
6759 ROYAL ORCHID CIRCLE  
DELRAY BEACH, FL 33446**

**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 \_\_\_\_\_ (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

**FILE NOW!! FEE IS \$150.00  
After May 1, 2005 Fee will be \$550.00**

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	PTD LIEBERFARB, ROSS 6759 ROYAL ORCHID CIRCLE DELRAY BEACH, FL 33446
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01/25/05-80075-020-150.00

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IN THIS SPACE**

12. 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 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:** *Ross Lieberfarb M.D.*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date \_\_\_\_\_ Daytime Phone # \_\_\_\_\_