
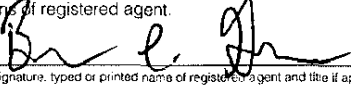
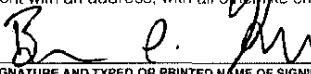


2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 24, 2004 8:00 am
Secretary of State

03-24-2004 90017 014 ***150.00

| | | | | | |
|---|--|--|---|--|--|
| DOCUMENT # P97000030501 | | | |  | |
| 1. Entity Name CANCER CARE SPECIALISTS, INC. | | | | | |
| Principal Place of Business BETHESDA CENTER FOR RAD/ONC 2815 SOUTH SEACREST BLVD. BOYNTON BEACH, FL 33435 | | | Mailing Address BETHESDA CENTER FOR RAD/ONC 2815 SOUTH SEACREST BLVD. BOYNTON BEACH, FL 33435 | | |
| 2. Principal Place of Business | | | 3. Mailing Address | | |
| Suite, Apt. #, etc. | | | Suite, Apt. #, etc. | | |
| City & State | | | City & State | | |
| Zip | Country | Zip | Country | 4. FEI Number 65-0764868 | |
| | | | | Applied For Not Applicable | |
| | | | | 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 | |
| GREENE, BRUCE D M.D. BETHESDA CENTER FOR RAD/ONC 2815 SOUTH SEACREST BLVD. BOYNTON BEACH, FL 33435 | | | | 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  DATE 3/22/04 | | | | | |
| (NOTE: Registered Agent signature required when reinstating) | | | | | |
| FILE NOW!!! FEE IS \$150.00 After May 1, 2004 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 | | | | | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | PD GREENE, BRUCE D M.D. 2815 SOUTH SEACREST BLVD. BOYNTON BEACH, FL 33435 | <input type="checkbox"/> Delete | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | SD SPEER, TOD W M.D. 2815 SOUTH SEACREST BLVD. BOYNTON BEACH, FL 33435 | <input checked="" type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | VPD PARSONS, JAMES T M.D. 2815 S. SEACREST BLVD. BOYNTON BEACH, FL 33435 | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| 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:  DATE 3/22/04 DAYTIME PHONE # 561-731-4891 | | | | | |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR | | | | | |