
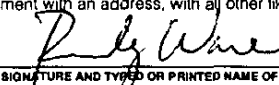


FILED
May 03, 2007 8:00 am
Secretary of State

05-03-2007 90032 041 ***150.00

**2007 FOR PROFIT CORPORATION
ANNUAL REPORT**

DOCUMENT # P97000044854			
1. Entity Name WEST COAST MEDICAL RESOURCES, INC.			
Principal Place of Business 235 BLUFF VIEW DRIVE LARGO, FL 33770		Mailing Address PO BOX 3884 SEMINOLE, FL 33775	
2. Principal Place of Business - No P.O. Box # 8200 113th Street		3. Mailing Address	
Suite, Apt. #, etc. Suite 102		Suite, Apt. #, etc.	
City & State Seminole FL		City & State	
Zip 33772	Country	Zip	Country
4. FEI Number 59-3446495		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 WARE, RANDY 235 BLUFF VIEW DRIVE BELLEAIR BLUFFS, FL 33770		7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) 8200 113th Street Suite 102 City Seminole FL Zip Code 33772	
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> DATE _____			
FILE NOW!!! FEE IS \$150.00 After May 1, 2007 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	PSD WARE, RANDY 235 BLUFF VIEW DRIVE BELLEAIR BLUFF, FL 33770 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY - ST - ZIP	PSD Ware, Randy 8200 113th Street, Suite 102 Seminole, FL 33772 <input checked="" 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
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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 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: 		Date: 4/30/07 723922800	
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR		Daytime Phone #	