

FILE NOW: FILING FEE AFTER MAY 1ST IS \$550.00


FILED

Feb 08, 1999 8:00am  
Secretary of State

02-08-1999 90042 020 \*\*\*150.00



DO NOT WRITE IN THIS SPACE

<b>PROFIT CORPORATION ANNUAL REPORT 1999</b>				FLORIDA DEPARTMENT OF STATE <b>Katherine Harris</b> Secretary of State DIVISION OF CORPORATIONS	
<b>DOCUMENT # P97000080673</b>					
1. Corporation Name <b>SIMONS &amp; GALLO, M.D., P.A.</b>					
Principal Place of Business <b>16800 NW 2ND AVENUE SUITE 607 MIAMI FL 33179</b>			Mailing Address <b>16800 NW 2ND AVENUE SUITE 607 MIAMI FL 33179</b>		
2. Principal Place of Business		2a. Mailing Address		3. Date Incorporated or Qualified	
21 Suite, Apt. #, etc.		26 Suite, Apt. #, etc.		09/17/1997	
22 City & State		27 City & State		4. FEI Number	
23 Zip		28 Zip		65-0783886	
24 33169		29 33169		5. Certificate of Status Desired	
25		30		<input type="checkbox"/> \$8.75 Additional Fee Required	
9. Name and Address of Current Registered Agent				10. Name and Address of New Registered Agent	
SIMONS, ROBERT L MD 16800 NW 2ND AVENUE SUITE 607 MIAMI FL 33179				81 Name	
				82 Street Address (P.O. Box Number is Not Acceptable)	
				83	
				84 City	
				85 Zip Code	
				FL 33169	
11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.					
SIGNATURE _____ DATE _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>					
12. OFFICERS AND DIRECTORS					
1.1 TITLE <input type="checkbox"/> DELETE					
1.2 NAME <b>SIMONS, ROBERT L MD</b>					
1.3 STREET ADDRESS <b>16800 NW 2ND AVENUE SUITE 607</b>					
1.4 CITY-ST-ZIP <b>MIAMI FL 33179</b>					
2.1 TITLE <input type="checkbox"/> DELETE					
2.2 NAME <b>GALLO, JULIO MD</b>					
2.3 STREET ADDRESS <b>16800 NW 2ND AVENUE SUITE 607</b>					
2.4 CITY-ST-ZIP <b>MIAMI FL 33179</b>					
3.1 TITLE <input type="checkbox"/> DELETE					
3.2 NAME					
3.3 STREET ADDRESS					
3.4 CITY-ST-ZIP					
4.1 TITLE <input type="checkbox"/> DELETE					
4.2 NAME					
4.3 STREET ADDRESS					
4.4 CITY-ST-ZIP					
5.1 TITLE <input type="checkbox"/> DELETE					
5.2 NAME					
5.3 STREET ADDRESS					
5.4 CITY-ST-ZIP					
6.1 TITLE <input type="checkbox"/> DELETE					
6.2 NAME					
6.3 STREET ADDRESS					
6.4 CITY-ST-ZIP					

14. 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: \_\_\_\_\_  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/19/99 (305) 651 9903  
Date Daytime Phone #

CR2E034 (11/98)