


**2004 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 27, 2004 08:00 AM
Secretary of State

DOCUMENT # P98000006021
1. Entity Name
DAVID DENNIS CASSIDY, M.D., P.A.



Principal Place of Business Mailing Address
885 CRANES COURT 1512 S ORANGE AVE
MAITLAND, FL 32751 ORLANDO, FL 32806

DO NOT WRITE IN THIS SPACE



01092004 No Chg-P CR2E034 (10/03)

4. FEI Number Applied For
59-3493303 Not Applicable

5. Certificate of Status Desired \$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent
CASSIDY, DAVID D MD
1512 S ORANGE AVE
ORLANDO, FL 32806

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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 _____
Signature, typed or printed name of registered agent and title if applicable (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. \$5.00 May Be Added to Fees

000000068-170
02/27/04-80042-012 150.00

10. OFFICERS AND DIRECTORS

TITLE	D
NAME	CASSIDY, DAVID D M.D.
STREET ADDRESS	885 CRANES COURT
CITY-ST-ZIP	MAITLAND, FL 32751
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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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)(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: DAVID D. CASSIDY, MD 1-25-04
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #