


PROFIT CORPORATION ANNUAL REPORT 1999		 FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS		FILED 99 MAR 22 AM 10:44 SECRETARY OF STATE TALLAHASSEE, FLORIDA													
DOCUMENT # P98000008484 1. Corporation Name WOOD OAKS FAMILY PRACTICE, P.A.																	
Principal Place of Business 150 SE 17TH STREET, STE. 504 OCALA FL 34471			Mailing Address 150 SE 17TH STREET, STE. 504 OCALA FL 34471														
DO NOT WRITE IN THIS SPACE																	
2. Principal Place of Business 21 Suite, Apt. #, etc. 22 City & State 23 Zip Country			2a. Mailing Address 26 Suite, Apt. #, etc. 27 City & State 28 Zip Country														
3. Date Incorporated or Qualified 01/01/1998			4. FEI Number 593456950														
5. Certificate of Status Desired <input type="checkbox"/>			\$8.75 Additional Fee Required														
6. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/>			\$5.00 May Be Added to Fees														
7. This corporation owes the current year Intangible Personal Property Tax. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			8. Name and Address of Current Registered Agent MOXLEY, JOHN 2320 NE 2ND ST., STE. 4 OCALA FL 34470														
9. Name and Address of Current Registered Agent			10. Name and Address of New Registered Agent 81 Name 82 Street Address (P.O. Box Number is Not Acceptable) 83 84 City FL 85 Zip Code														
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 _____ Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reappointing)																	
12. OFFICERS AND DIRECTORS																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> TITLE NAME STREET ADDRESS CITY-ST-ZIP </td> <td style="width: 50%;"> 1.1 TITLE 1.2 NAME 1.3 STREET ADDRESS 1.4 CITY-ST-ZIP </td> </tr> <tr> <td> TITLE NAME STREET ADDRESS CITY-ST-ZIP </td> <td> 2.1 TITLE 2.2 NAME 2.3 STREET ADDRESS 2.4 CITY-ST-ZIP </td> </tr> <tr> <td> TITLE NAME STREET ADDRESS CITY-ST-ZIP </td> <td> 3.1 TITLE 3.2 NAME 3.3 STREET ADDRESS 3.4 CITY-ST-ZIP </td> </tr> <tr> <td> TITLE NAME STREET ADDRESS CITY-ST-ZIP </td> <td> 4.1 TITLE 4.2 NAME 4.3 STREET ADDRESS 4.4 CITY-ST-ZIP </td> </tr> <tr> <td> TITLE NAME STREET ADDRESS CITY-ST-ZIP </td> <td> 5.1 TITLE 5.2 NAME 5.3 STREET ADDRESS 5.4 CITY-ST-ZIP </td> </tr> <tr> <td> TITLE NAME STREET ADDRESS CITY-ST-ZIP </td> <td> 6.1 TITLE 6.2 NAME 6.3 STREET ADDRESS 6.4 CITY-ST-ZIP </td> </tr> </table>						TITLE NAME STREET ADDRESS CITY-ST-ZIP	1.1 TITLE 1.2 NAME 1.3 STREET ADDRESS 1.4 CITY-ST-ZIP	TITLE NAME STREET ADDRESS CITY-ST-ZIP	2.1 TITLE 2.2 NAME 2.3 STREET ADDRESS 2.4 CITY-ST-ZIP	TITLE NAME STREET ADDRESS CITY-ST-ZIP	3.1 TITLE 3.2 NAME 3.3 STREET ADDRESS 3.4 CITY-ST-ZIP	TITLE NAME STREET ADDRESS CITY-ST-ZIP	4.1 TITLE 4.2 NAME 4.3 STREET ADDRESS 4.4 CITY-ST-ZIP	TITLE NAME STREET ADDRESS CITY-ST-ZIP	5.1 TITLE 5.2 NAME 5.3 STREET ADDRESS 5.4 CITY-ST-ZIP	TITLE NAME STREET ADDRESS CITY-ST-ZIP	6.1 TITLE 6.2 NAME 6.3 STREET ADDRESS 6.4 CITY-ST-ZIP
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13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12 <input type="checkbox"/> Change <input type="checkbox"/> Addition																	

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: _____

 PAMELA LEWIN
 PAMELA LEWIN
 M.D.

 1-6-99 352 629 2250
 Date Daytime Phone #

CR2E034 (11/98)