2005 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 27, 2005 8:00 am
Secretary of State
01-27-2005 90058 009 ***150.00

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01172005 Chg-P CR2E034 (10/03)

DOCUMENT # P98000015454

1. Entity Name
LOST KEY ANIMAL CLINIC, P.A.

Principal Place of Business	Mailing Address
4190 BAUER ROAD PENSACOLA, FL 32506	4190 BAUER ROAD PENSACOLA, FL 32506

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 59-3502499 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
HOSKIN, CHARLES P 445 E. GOVERNMENT STREET PENSACOLA, FL 32501	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
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, 2005 Fee will be $550.00

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	D	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	CALLOWAY, SUE		NAME	
STREET ADDRESS	11005 BRIDGES CT DR		STREET ADDRESS	
CITY-ST-ZIP	PENSACOLA, FL		CITY-ST-ZIP	
TITLE	D	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	MCDOUGAL, SUE		NAME	
STREET ADDRESS	951 SHADOW RIDGE		STREET ADDRESS	
CITY-ST-ZIP	PENSACOLA, FL		CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	

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: Susan G. Calloway DVM / Susan G. Calloway, DVM 1-25-04 850-492-6878
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #