


**2005 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Mar 10, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # P98000037211</b> 1. Entity Name <b>DAVID M. KLEIN, M.D., OPHTHALMOLOGIST, P.A.</b>	
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Principal Place of Business <b>1600 TAMiami TRAIL STE 101 PORT CHARLOTTE, FL 33948</b>	Mailing Address <b>1600 TAMiami TRAIL STE 101 PORT CHARLOTTE, FL 33948</b>
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02212005 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number <b>65-0829646</b>	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75 Additional Fee Required</b>	

<b>6. Name and Address of Current Registered Agent</b>  <b>KLEIN, DAVID M M.D. 1600 TAMiami TR STE 101 PORT CHARLOTTE, FL 33948</b>	<b>DO NOT WRITE IN THIS SPACE</b>
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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 \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

<b>FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00</b>	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b>
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D KLEIN, DAVID M M.D. 1600 TAMiami TR STE 101 PORT CHARLOTTE, FL
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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:** David M. Klein **DAVID M. KLEIN, MD**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR **PRESIDENT** 2/20/05 941-764-0632  
Date Daytime Phone #