


2004 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Apr 20, 2004 8:00 am
Secretary of State

04-05-2004 90403 006 ***150.00

DOCUMENT # P98000054802	
1. Entity Name GLOBAL MEDICAL MANAGEMENT ASSOCIATES, INC.	

Principal Place of Business 2727 E. OAKLAND PARK BLVD., STE 205C FORT LAUDERDALE FL 33306	Mailing Address PO BOX 480191 FT LAUDERDALE FL 33348-0191
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2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



MOORE CR2E034 (11/03)

4. FEI Number APPLIED FOR		<input checked="" type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required
6. Name and Address of Current Registered Agent SAYET, PETER 2727 E. OAKLAND PARK BLVD., STE 205C FORT LAUDERDALE FL 33306		7. Name and Address of New Registered Agent 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

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

FILE NOW!!! FEE IS \$150.00
After May 1, 2004 Fee will be \$550.00
Make Check Payable to Florida Department of State

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 NAME STREET ADDRESS CITY-ST-ZIP	D SAYET, PETER H 201 ALHAMBRA CIRCLE 8TH FLOOR CORAL GABLES FL 33134 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

04-01-04

Date

954-537-3483

Daytime Phone #

Attachment

12/04/3460

#P99000054802

Form **SS-4****Application for Employer Identification Number**

(Rev. December 2001)

Department of the Treasury
Internal Revenue Service(For use by employers, corporations, partnerships, trusts, estates, churches,
government agencies, Indian tribal entities, certain individuals, and others.)

▶ See separate instructions for each line. ▶ Keep a copy for your records.

EIN

OMB No. 1545-0003

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested <i>Global Medical Management Associates, Inc.</i>		
	2 Trade name of business (if different from name on line 1)	3 Executor, trustee, "care of" name	
	4a Mailing address (room, apt., suite no. and street, or P.O. box) <i>P.O. Box 480191</i>	5a Street address (if different) (Do not enter a P.O. box.)	
	4b City, state, and ZIP code <i>Ft. Lauderdale, FL 33348-0191</i>	5b City, state, and ZIP code	
	6 County and state where principal business is located <i>Broward, Florida</i>		
	7a Name of principal officer, general partner, grantor, owner, or trustor <i>Peter Sayot</i>		7b SSN, ITIN, or EIN <i>261-90-0659</i>
8a Type of entity (check only one box)			
<input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership _____ <input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ _____ <input type="checkbox"/> Personal service corp. _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input type="checkbox"/> Other (specify) ▶ _____			
<input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Plan administrator (SSN) _____ <input type="checkbox"/> Trust (SSN of grantor) _____ <input type="checkbox"/> National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises Group Exemption Number (GEN) ▶ _____			
8b If a corporation, name the state or foreign country (if applicable) where incorporated		State <i>Florida</i>	Foreign country
9 Reason for applying (check only one box)			
<input type="checkbox"/> Started new business (specify type) ▶ _____ <input type="checkbox"/> Banking purpose (specify purpose) ▶ _____ <input type="checkbox"/> Changed type of organization (specify new type) ▶ _____ <input type="checkbox"/> Purchased going business _____ <input type="checkbox"/> Hired employees (Check the box and see line 12.) <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Created a pension plan (specify type) ▶ _____ <input checked="" type="checkbox"/> Other (specify) ▶ <i>To file corporate state filing</i>			
10 Date business started or acquired (month, day, year) <i>December 2003</i>		11 Closing month of accounting year <i>December</i>	
12 First date wages or annuities were paid or will be paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year) ▶ <i>Not yet known</i>			
13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter "0-". ▶		Agricultural -0-	Household -0-
14 Check one box that best describes the principal activity of your business.			
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> Other (specify) <i>Holding Company</i>			
15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. <i>None</i>			
16a Has the applicant ever applied for an employer identification number for this or any other business? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Note: If "Yes," please complete lines 16b and 16c.			
16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above. Legal name ▶ _____ Trade name ▶ _____			
16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (mo., day, year) _____ City and state where filed _____ Previous EIN _____			
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.		
	Designee's name		Designee's telephone number (include area code) ()
	Address and ZIP code		Designee's fax number (include area code) ()
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.			
Name and title (type or print clearly) ▶ <i>Peter Sayot President</i>		Applicant's telephone number (include area code) (954) 537-3483	
Signature ▶ <i>[Signature]</i>		Applicant's fax number (include area code) ()	
Date ▶ <i>03-29-04</i>			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 16055N

Form **SS-4** (Rev. 12-2001)