

FILED
Jul 09, 1999 8:00 am
Secretary of State

07-09-1999 90020 026 ***150.00

AMOUNT DUE ON OR BEFORE 8/15/99: \$350 (IF UNPAID, MINIMUM AMOUNT DUE TO REINSTATE: \$750).

**PROFIT
CORPORATION
ANNUAL REPORT
1999**



FLORIDA DEPARTMENT OF STATE
Katherine Harris
 Secretary of State
 DIVISION OF CORPORATIONS

DOCUMENT # P98000086472

1. Corporation Name

HAWTHORNE MEDICAL CENTER, P.A.

Principal Place of Business

21115 S.E. 179TH PLACE
LOCHLOOSA FL 32662

Mailing Address

P.O. BOX 180
LOCHLOOSA FL 32662

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified

10/07/1998

4. FEI Number

59-3537283

☒ Applied For☐ Not Applicable5. Certificate of Status Desired ☐\$8.75 Additional
Fee Required6. Election Campaign Financing
Trust Fund Contribution ☐\$5.00 May Be
Added to Fees8. This corporation owes the current year
Intangible Personal Property. ☐ Yes ☒ No

10. Name and Address of New Registered Agent

Principal Place of Business

302 SW 2nd Ave

Suite, Apt. #, etc.

2a. Mailing Address

26 302 SW 2nd Ave

Suite, Apt. #, etc.

City & State

Hawthorne FL

Zip

32640

Country

25 Alachua

City & State

28 Hawthorne FL

Zip

29 32640

Country

30 Alachua

9. Name and Address of Current Registered Agent

COLASANTE, ONA M.D.
 21115 S.E. 179TH PLACE
 LOCHLOOSA FL 32662

302 SW 2nd Ave
 Lochloosa Hawthorne FL 32640

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

I. 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

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

(NOTE: Registered Agent signature required when reinstating)

DATE

OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1E	D	<input type="checkbox"/> DELETE
1E	COLASANTE, ONA M.D.	
1E	21115 S.E. 179TH PLACE	
1E	LOCHLOOSA FL 32662	
2E		<input type="checkbox"/> DELETE
2E		
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2E		<input type="checkbox"/> DELETE
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2E		<input type="checkbox"/> DELETE
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2E		

1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
1.2 NAME	
1.3 STREET ADDRESS	
1.4 CITY-ST-ZIP	
2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
2.2 NAME	
2.3 STREET ADDRESS	
2.4 CITY-ST-ZIP	
3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
3.2 NAME	
3.3 STREET ADDRESS	
3.4 CITY-ST-ZIP	
4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
4.2 NAME	
4.3 STREET ADDRESS	
4.4 CITY-ST-ZIP	
5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
5.2 NAME	
5.3 STREET ADDRESS	
5.4 CITY-ST-ZIP	
6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
6.2 NAME	
6.3 STREET ADDRESS	
6.4 CITY-ST-ZIP	

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 807, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed or on an attachment with an address.

SIGNATURE:

SIGNATURE REQUIRED

7-4-99

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (5/99)