


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 03, 2008 08:00 AM
Secretary of State

DOCUMENT # P98000086472	
1. Entity Name HAWTHORNE MEDICAL CENTER, P.A.	

Principal Place of Business 21815 SOUTHEAST 71ST AVENUE HAWTHORNE, FL 32640 US	Mailing Address 21815 SOUTHEAST 71ST AVENUE HAWTHORNE, FL 32640 US
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DO NOT WRITE IN THIS SPACE



03232008 No Chg-P CR2E034 (11/05)

4. FEI Number 59-3537283	Applied For Not Applicable
5. Certificate of Status Desired <input checked="" type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

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

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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 _____ (NOTE: Registered Agent signature required when reinstating)

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

FILE NOW!!! FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	000000879596 04/15/08-80025-023 158.75
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10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	D COLASANTE, ONA M.D. 21115 S.E. 179TH PLACE LOCHLOOSA, FL 32662
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T LAWLEY, MIKE 1735 W. HIBISCUS BLVD. STE 200 MELBOURNE, FL 32901
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	

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12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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:  **4/1/08 352 481 2400**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

ONA COLASANTE M.D