FAX 863 676 8899 BUNTING TRIPP & INGL

FILED
Aug 04, 2004 8:00 am
Secretary of State

08-04-2004 90016 016 ***150.00

2004 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # P98000104520

1. Entity Name
A. B. ROA MEDICAL CENTER, P.A.

54066756

Principal Place of Business
P.O. BOX 2829
LAKE PLACID, FL 33862-2829

Mailing Address
PO BOX 2829
LAKE PLACID, FL 33862

2. Principal Place of Business

Suite, Apt. #, etc.

City & State

Zip | Country

3. Mailing Address

Suite, Apt. #, etc.

City & State

Zip | Country

07272004 Chg-P CR2E034 (10/03)

4. FEI Number
65-0884511

Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

ROA, ANTONIO B M.D.
201 U.S. HIGHWAY 27 SOUTH
LAKE PLACID, FL 33852

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
Due by September 8, 2004

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

In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.

10. OFFICERS AND DIRECTORS

TITLE	OP	☐ Delete
NAME	ROA, ANTONIO B M.D.	
STREET ADDRESS	201 U.S. HWY 27 SOUTH	
CITY-ST-ZIP	LAKE PLACID, FL 33852	
TITLE		☐ Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Delete
NAME		
STREET ADDRESS		
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TITLE		☐ Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE		☐ Change ☐ Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Change ☐ Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Change ☐ Addition
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NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		☐ Change ☐ Addition
NAME		
STREET ADDRESS		
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: ARoa M.D ANTONIO B. ROA, M.D 7-28-04 (863) 465-6200
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR | Date | Daytime Phone #