


2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jan 23, 2004 08:00 AM
Secretary of State

DOCUMENT # P99000016128

1. Entity Name
GALLOWAY MEDICAL SURGICAL CENTER, INC.



Principal Place of Business
**825 SW 87TH AVE., SUITE I
 MIAMI, FL 33174**

Mailing Address
**825 SW 87TH AVE., SUITE I
 MIAMI, FL 33174**

DO NOT WRITE IN THIS SPACE



01132004 No Chg-P CR2E034 (10/03)

4. FEI Number
65-0905931 Applied For
 Not Applicable

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

6. Name and Address of Current Registered Agent

**CRUZ, ROBERTO
 825 SW 87TH AVE., SUITE I
 MIAMI, FL 33174**

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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 _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS \$150.00 After May 1, 2004 Fee will be \$550.00

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

10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY - ST - ZIP	PTD CRUZ, ROBERTO 825 SW 87TH AVE., SUITE I MIAMI, FL 33174
TITLE NAME STREET ADDRESS CITY - ST - ZIP	VSD CRUZ, ARMANDO 825 SW 87TH AVE., SUITE I MIAMI, FL 33174
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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:  DATE: **1-16-04** Daytime Phone # _____

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR