

**2004 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Mar 02, 2004 08:00 AM**  
**Secretary of State**

**DOCUMENT # P99000018517**

1. Entity Name  
**ST. LUCIE SURGICAL CENTER, P.A.**



Principal Place of Business  
**1300 N LAWNWOOD CIRCLE  
FORT PIERCE, FL 34950**

Mailing Address  
**1300 N LAWNWOOD CIRCLE  
FORT PIERCE, FL 34950**



02172004 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number <b>65-0899311</b>	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	<b>\$8.75 Additional Fee Required</b>

**6. Name and Address of Current Registered Agent**

**KATTA, JOSEPH J M.D.  
1300 N. LONGWOOD CIR.  
FT. PIERCE, FL 34950**

**DO NOT WRITE  
IN THIS SPACE**

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**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

**\$5.00 May Be  
Added to Fees**

**U000000073480  
03/02/04-80038-004 150.00**

**10. OFFICERS AND DIRECTORS**

TITLE NAME STREET ADDRESS CITY-ST-ZIP	DVT KATTA, JOSEPH J M.D. 1900 NEBRASKA AVE., STE. 5 FT. PIERCE, FL 34950
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DPS KORLIPARA, A. PRASAD R. M.D. 1900 NEBRASKA AVE., STE. 5 FT. PIERCE, FL 34950
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	

**DO NOT WRITE  
IN THIS SPACE**

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

Date

Daytime Phone #