

# 2005 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

**FILED**  
**Apr 23, 2005 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # P99000039996</b>	
1. Entity Name CHARLOTTE DENTAL ASSOCIATION, P.A.	



Principal Place of Business 2595 HARBOR BLVD. SUITE 109 PORT CHARLOTTE FL 33952	Mailing Address 2595 HARBOR BLVD. SUITE 109 PORT CHARLOTTE FL 33952
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2. Principal Place of Business		3. Mailing Address	
Suite, Apt #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



1st MOORE CR2E034 (10/04)

4. FEI Number 65-0916232	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent  GASSMAN, ALAN S ESQ. 1245 COURT STREET SUITE 102 CLEARWATER FL 33746		7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code	
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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) DATE \_\_\_\_\_

**FILE NOW!!! FEE IS \$150.00**  
**After May 1, 2005 Fee Will Be \$550.00**  
**Make Check Payable to Florida Department of State**

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

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY- ST- ZIP	D WATTERS, JOHN D.M.D. 2595 HARBOR BLVD., SUITE 109 PORT CHARLOTTE FL 33952 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Add 000000325652 04/23/05-80023-025 150.00
TITLE NAME STREET ADDRESS CITY- ST- ZIP	D BENDER, JOSEPH D.M.D. 2595 HARBOR BLVD., SUITE 109 PORT CHARLOTTE FL 33952 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Add
TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Add
TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Add
TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Add
TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Add

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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: John L. Watters, D.M.D. JOHN L. WATTERS, D.M.D. 4/20/05 (941) 625-2908  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone