


# 2007 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Apr 12, 2007 8:00 am**  
**Secretary of State**

04-12-2007 90028 027 \*\*\*150.00

<b>DOCUMENT # P99000039996</b> 1. Entity Name <b>CHARLOTTE DENTAL ASSOCIATION, P.A.</b>					
Principal Place of Business <b>2595 HARBOR BLVD. SUITE 109 PORT CHARLOTTE, FL 33952</b>			Mailing Address <b>2595 HARBOR BLVD. SUITE 109 PORT CHARLOTTE, FL 33952</b>		
2. Principal Place of Business - No P.O. Box # <b>19240 QUESADA AVE</b> Suite, Apt. #, etc.		3. Mailing Address <b>19240 QUESADA AVE</b> Suite, Apt. #, etc.			
City & State <b>Port Charlotte, FL</b> Zip <b>33948</b>		City & State <b>Port Charlotte, FL</b> Zip <b>33948</b>		4. FEI Number <b>65-0916232</b>	
Country <b>USA</b>		Country <b>USA</b>		5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75 Additional Fee Required</b>	
6. Name and Address of Current Registered Agent  <b>GASSMAN, ALAN S ESQ. 1245 COURT STREET SUITE 102 CLEARWATER, FL 33746</b>				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <b>FL</b> 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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____					
<b>FILE NOW!!! FEE IS \$150.00 After May 1, 2007 Fee will be \$550.00</b>			9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b>		
<b>10. OFFICERS AND DIRECTORS</b>			<b>11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11</b>		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>D</b> <b>WATTERS, JOHN D.M.D.</b> <b>2595 HARBOR BLVD., SUITE 109</b> <b>PORT CHARLOTTE, FL 33952</b> <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>D</b> <b>BENDER, JOSEPH D.M.D.</b> <b>2595 HARBOR BLVD., SUITE 109</b> <b>PORT CHARLOTTE, FL 33952</b> <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
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"/> Addition	
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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"/> Addition	
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.					
<b>SIGNATURE: <u>John L. Watters, DMD</u> / <u>JOHN L. WATTERS, DMD</u> 4/2/07 743-7435</b> SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #					

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