

DOCUMENT # P99000096175

1. Entity Name

AAA ANESTHESIA SERVICES, PA

03-15-2000 90046 008 ***150.00

| | |
|---|--|
| Principal Place of Business | Mailing Address |
| 5173 ATLANTIC VIEW ST AUGUSTINE FL 32084 | 5173 ATLANTIC VIEW ST AUGUSTINE FL 32084-7143 |

| | | | |
|---------------------------------------|---------|---------------------------|---------|
| 2. Principal Place of Business | | 3. Mailing Address | |
| Suite, Apt. #, etc. | | Suite, Apt. #, etc. | |
| City & State | | City & State | |
| Zip | Country | Zip | Country |



DO NOT WRITE IN THIS SPACE

| 6. Name and Address of Current Registered Agent | | 7. Name and Address of New Registered Agent | |
|---|--|--|-----------------------------------|
| MARTIN, KATHERINE 5173 ATLANTIC VIEW ST AUGUSTINE FL 32084 | | Name | |
| | | Street Address (P.O. Box Number is Not Acceptable) | |
| | | | |
| | | City | <div>FL</div> <div>Zip Code</div> |

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.

SIGNATURE Katherine Mark 3/2/00
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

| | | |
|--|--|---|
| <p>9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. <input checked="" type="checkbox"/> (See criteria on back)</p> | <p>FILE NOW!!! FEE IS \$150.00 After MAY 1, 2000 Fee will be \$550.00 Make Check Payable to Department of State</p> | <p>10. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/> \$5.00 May Be Added to Fees</p> |
|--|--|---|

| 11. OFFICERS AND DIRECTORS | | 12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | |
|--|--|---|---|
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | P MARTIN, KATHERINE 5173 ATLANTIC VIEW ST AUGUSTINE FL 32084 <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 |
| 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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13. 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 11 or Block 12 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

3/2/00
Date

Date _____

904-461-0652

Daytime Phone #

CR2E034 (9/99)