

3-18-97 B-3184 C  
FILE NOW: FILING FEE AFTER MAY 1 IS \$550.00

FILED  
Mar 18 1997 8:00am  
Secretary of State

PROFIT CORPORATION ANNUAL REPORT <b>1997</b>		FLORIDA DEPARTMENT OF STATE <b>Sandra B. Mortham</b> Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # **S69537** (6)  
1. Corporation Name  
**ANESTHESIOLOGISTS PROFESSIONAL ASSURANCE COMPANY  
(A RISK RETENTION GROUP)**



Principal Place of Business <b>801 ARTHUR GODFREY ROAD SUITE 400 MIAMI BEACH FL 33140</b>	Mailing Address <b>801 ARTHUR GODFREY ROAD SUITE 400 MIAMI BEACH FL 33140-3323</b>
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3. Date Incorporated or Qualified <b>07/23/1991</b>	3a. Date of Last Report <b>03/18/1996</b>
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2. Principal Place of Business 21 Suite, Apt. #, etc. 22 City & State 23 Zip 24 Country	2a. Mailing Address 26 Suite, Apt. #, etc. 27 City & State 28 Zip 29 Country	4. FEI Number <b>59-2820748</b> Applied For Not Applicable	5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75 Additional Fee Required</b>	6. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b>	8. This corporation has liability for intangible tax under s. 199.032, Florida Statutes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Consolidated</b>
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9. Name and Address of Current Registered Agent

**INSURANCE COMMISSIONER  
THE CAPITOL BUILDING  
TALLAHASSEE FL 32399**

10. Name and Address of New Registered Agent

81 Name	82 Street Address (P.O. Box Number is Not Acceptable)	83	84 City	85 Zip Code
			<b>FL</b>	

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	CDPT	1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	MOYA, M.D. F	1.2 NAME	
STREET ADDRESS	801 ARTHUR GODFREY RD	1.3 STREET ADDRESS	
CITY - ST - ZIP	MIAMI BEACH FL	1.4 CITY - ST - ZIP	
TITLE	DS	2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	MCMULTY, JOAN	2.2 NAME	
STREET ADDRESS	801 ARTHUR GODFREY RD	2.3 STREET ADDRESS	
CITY - ST - ZIP	MIAMI BEACH FL	2.4 CITY - ST - ZIP	
TITLE	D	3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	VILES, M.D. R	3.2 NAME	
STREET ADDRESS	801 ARTHUR GODFREY RD	3.3 STREET ADDRESS	
CITY - ST - ZIP	MIAMI BEACH FL	3.4 CITY - ST - ZIP	
TITLE	DV	4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	LICHTIGER, M.D. M	4.2 NAME	
STREET ADDRESS	801 ARTHUR GODFREY RD	4.3 STREET ADDRESS	
CITY - ST - ZIP	MIAMI BEACH FL	4.4 CITY - ST - ZIP	
TITLE	DV	5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	MARSHALL, M.D. J	5.2 NAME	
STREET ADDRESS	801 ARTHUR GODFREY RD	5.3 STREET ADDRESS	
CITY - ST - ZIP	MIAMI BEACH FL	5.4 CITY - ST - ZIP	
TITLE	DV	6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	WITELS, M.D. S	6.2 NAME	
STREET ADDRESS	801 ARTHUR GODFREY RD	6.3 STREET ADDRESS	
CITY - ST - ZIP	MIAMI BEACH FL	6.4 CITY - ST - ZIP	

14. I do 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 annual report or supplemental annual 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 12 or Block 13 if changed, or in the attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**Frank Moya, M.D.** 3/12/97 305/673/4387

Date

Daytime Phone #

0193106

CR2E034 (9/96)