

SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER AUGUST 7, 1996.
AMOUNT DUE ON OR BEFORE 8/7/96: \$225 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$375.)

PROFIT CORPORATION ANNUAL REPORT 1996



FLORIDA DEPARTMENT OF STATE
 Sandra B. Morham
 Secretary of State
 DIVISION OF CORPORATIONS

DOCUMENT # **S90881 (1)**

1. Corporation Name
REHABILITATION PHYSICIANS OF THE PALM BEACHES, P.A.



Principal Place of Business Mailing Address
300 ROYAL PALM WAY PALM BEACH FL 33480

2. Principal Place of Business		2a. Mailing Address		3. Date Incorporated or Qualified	3a. Date of Last Report
21	Suite, Apt #, etc	26	Suite, Apt #, etc	10/30/1991	05/01/1995
22	City & State	27	City & State	4. FEI Number	Applied For
23	Zip	28	Zip	65-0296151	Not Applicable
24	Country	29	Country	5. Certificate of Status Desired	\$8.75 Additional Fee Required
		30		<input type="checkbox"/>	\$5.00 May Be Added to Fees
				6. Election Campaign Financing Trust Fund Contribution	<input type="checkbox"/>
				8. This corporation has liability for intangible tax under s. 199.032, Florida Statutes	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Name and Address of Current Registered Agent				10. Name and Address of New Registered Agent			
FUCHS, LARRY 590 ROYAL PALM BEACH BLVD. ROYAL PALM BEACH FL 33411				81	Name		
				82	Street Address (P.O. Box Number is Not Acceptable)		
				83			
				84	City	FL	85

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 _____ DATE _____
Signature of the registered agent and the applicable (if 201) Registered Agent signature required when four (4) days.

12. OFFICERS AND DIRECTORS				13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12			
TITLE	PD	<input type="checkbox"/> DELETE		11 TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	LAKATOSH, DONALD A.			12 NAME			
STREET ADDRESS	300 ROYAL PALM WAY			13 STREET ADDRESS			
CITY - ST - ZIP	PALM BEACH FL			14 CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE		<input type="checkbox"/> DELETE		21 TITLE			
NAME				22 NAME			
STREET ADDRESS				23 STREET ADDRESS			
CITY - ST - ZIP				24 CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE		<input type="checkbox"/> DELETE		31 TITLE			
NAME				32 NAME			
STREET ADDRESS				33 STREET ADDRESS			
CITY - ST - ZIP				34 CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE		<input type="checkbox"/> DELETE		41 TITLE			
NAME				42 NAME			
STREET ADDRESS				43 STREET ADDRESS			
CITY - ST - ZIP				44 CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE		<input type="checkbox"/> DELETE		51 TITLE			
NAME				52 NAME			
STREET ADDRESS				53 STREET ADDRESS			
CITY - ST - ZIP				54 CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE		<input type="checkbox"/> DELETE		61 TITLE			
NAME				62 NAME			
STREET ADDRESS				63 STREET ADDRESS			
CITY - ST - ZIP				64 CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition	

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), 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 617, Florida Statutes, and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE: **TIMOTHY E. WASKIEWICZ**, 6/17/96 (407) 659-5443
 PRACTICE ADMINISTRATOR

CR2E034 (3/96)