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Apr 20, 1999 8:00 am
Secretary of State

04-20-1999 90292 013 ***150.00

PROFIT CORPORATION
 ANNUAL REPORT
1999



FLORIDA DEPARTMENT OF STATE
Katherine Harris
 Secretary of State
 DIVISION OF CORPORATIONS

DOCUMENT # V07361

1. Corporation Name
SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE, P. A.



DO NOT WRITE IN THIS SPACE

Principal Place of Business
**509 RIVERSIDE DR
 SUITE 302
 STUART FL 34994
 US**

Mailing Address
**509 RIVERSIDE DR
 SUITE 302
 STUART FL 34994
 US**

3. Date Incorporated or Qualified

01/16/1992

2. Principal Place of Business

2a. Mailing Address

4. FEI Number

65-0311858

Applied For
 Not Applicable

21 Suite, Apt. #, etc.

26 Suite, Apt. #, etc.

5. Certificate of Status Desired

\$8.75 Additional Fee Required

22 City & State

27 City & State

6. Election Campaign Financing Trust Fund Contribution

\$5.00 May Be Added to Fees

23 Zip

Country

28 Zip

Country

8. This corporation owes the current year Intangible Personal Property Tax. Yes No

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

**COEL, MARK A
 4000 HOLLYWOOD BLVD.
 SUITE 350 NORTH
 HOLLYWOOD FL 33021**

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

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 DELETE
 NAME **PD ANSPACH, W.E. III M.D.**
 STREET ADDRESS **509 RIVERSIDE DRIVE SUITE 302**
 CITY-ST-ZIP **STUART FL 34994**

1.1 TITLE Change Addition
 1.2 NAME
 1.3 STREET ADDRESS
 1.4 CITY-ST-ZIP

TITLE DELETE
 NAME **VD CARLSON, W.E. M.D.**
 STREET ADDRESS **509 RIVERSIDE DRIVE SUITE 302**
 CITY-ST-ZIP **STUART FL 34994**

2.1 TITLE Change Addition
 2.2 NAME
 2.3 STREET ADDRESS
 2.4 CITY-ST-ZIP

TITLE DELETE
 NAME **SD DESMAN, SCOTT M.D.**
 STREET ADDRESS **509 RIVERSIDE DRIVE SUITE 302**
 CITY-ST-ZIP **STUART FL 34994**

3.1 TITLE Change Addition
 3.2 NAME
 3.3 STREET ADDRESS
 3.4 CITY-ST-ZIP

TITLE DELETE
 NAME **TD KIM, DAVID M.D.**
 STREET ADDRESS **509 RIVERSIDE DRIVE SUITE 302**
 CITY-ST-ZIP **STUART FL 34994**

4.1 TITLE Change Addition
 4.2 NAME
 4.3 STREET ADDRESS
 4.4 CITY-ST-ZIP

TITLE DELETE
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

5.1 TITLE Change Addition
 5.2 NAME **Haas, George M.D.**
 5.3 STREET ADDRESS **509 Riverside Drive Suite 302**
 5.4 CITY-ST-ZIP **Stuart, FL 34994**

TITLE DELETE
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

6.1 TITLE Change Addition
 6.2 NAME
 6.3 STREET ADDRESS
 6.4 CITY-ST-ZIP

14. 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 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 an attachment with an address, with all other like empowered.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

W. E. CARLSON M.D.

Date

4-13-99

Daytime Phone #

561 223 5980

CR2E034 (1/98)