FILED
Apr 18, 2007 8:00 am
Secretary of State
03-05-2007 90067 012 *****8.75
04-18-2007 90165 020 ***141.25

2007 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # V07883

1. Entity Name
WILLIAM B. THOMPSON, JR., M.D., P.A.

40066957

Principal Place of Business	Mailing Address
WILLIAM B THOMPSON MD 2120 SW 22ND PLACE OCALA, FL 34474 US	WILLIAM B THOMPSON MD 2120 SW 22ND PLACE OCALA, FL 34474

01222007 No Chg-P CR2E034 (11/05)

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4. FEI Number
59-3169327
☐ Applied For
☐ Not Applicable

5. Certificate of Status Desired ☐ $8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

THOMPSON, WILLIAM B MD
2120 SW 22ND PLACE
OCALA, FL 34474

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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 _____ DATE
Signature, type or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS $150.00
After May 1, 2007 Fee will be $550.00

9. Election Campaign Financing Trust Fund Contribution. ☐ $5.00 May Be Added to Fees

10. OFFICERS AND DIRECTORS

TITLE	P
NAME	THOMPSON, WILLIAM B MD
STREET ADDRESS	2120 SW 22ND PLACE
CITY-ST-ZIP	OCALA, FL 34474
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
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CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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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.

SIGNATURE: Wm B. Thompson MD 2/4/7
SIGNATURE AND TYPED OR PRINTED NAME OF INDIVIDUAL OFFICER OR DIRECTOR Date Daytime Phone #

William B. Thompson MD