

# **2012 FOR PROFIT CORPORATION ANNUAL REPORT**

DOCUMENT# V08254

**FILED**  
**Mar 23, 2012**  
**Secretary of State**

**Entity Name:** ASSOCIATED FAMILY MEDICINE II, P.A.

**Current Principal Place of Business:**

515 W SR 434  
110  
LONGWOOD, FL 32750

**New Principal Place of Business:**

**Current Mailing Address:**

PO BOX 915201  
LONGWOOD, FL 327915201

**New Mailing Address:**

**FEI Number:** 59-3106061

**FEI Number Applied For ( )**

**FEI Number Not Applicable ( )**

**Certificate of Status Desired ( )**

**Name and Address of Current Registered Agent:**

STOGIS, ROBERT  
320 SABAL PALM PLACE  
300  
LONGWOOD, FL 32779 US

**Name and Address of New Registered Agent:**

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:

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**OFFICERS AND DIRECTORS:**

Title: PD  
Name: VYAS, ZABUNNISA  
Address: 320 W. SABAL PALM PLACE, SUITE 300  
City-St-Zip: LONGWOOD, FL 32779

Title: V  
Name: VYAS, SUREE  
Address: 320 W. SABAL PALM PLACE, SUITE 300  
City-St-Zip: LONGWOOD, FL 32779

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 above, or on an attachment with all other like empowered.

SIGNATURE: ZABUNNISSA VYAS

DP

03/23/2012

\_\_\_\_\_  
Electronic Signature of Signing Officer or Director

\_\_\_\_\_  
Date