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CORPORATION ANNUAL REPORT
1995

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

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
95 MAR 14 AM 9:57

DOCUMENT # **V41951** **(7)**

1. Corporation Name
COMPREHENSIVE PAIN MEDICINE, P.A.

Principal Place of Business	Mailing Address
5149 N. 9TH AVE. STE. 306 PENSACOLA FL 32504 US	PO BOX 30328 SUITE 344 PENSACOLA FL 32503 US

DO NOT WRITE IN THIS SPACE.

3. Date Incorporated or Qualified: 06/05/1992	3a. Date of Last Report: 02/23/1994
4. FEI Number: 59-3129628	Applied For ☐ Not Applicable ☐
5. Certificate of Status Desired ☐	$8.75 Additional Fee Required
6. Election Campaign Financing Trust Fund Contribution ☐	$5.00 May Be Added to Fees
8. The corporation has liability for intangible tax under S. 199.032, Florida Statutes ☒ Yes ☐ No	

2. Principal Place of Business	2a. Mailing Address
21 4412 N. Davis Hwy	26 4412 N. Davis Hwy
22 Suite, Apt. #, etc.	27 Suite, Apt. #, etc.
23 City & State: Pensacola, FL	28 City & State: Pensacola FL
24 Zip: 32503 25 Country: US	29 Zip: 32503 30 Country: US

9. Name and Address of Current Registered Agent

LOZIER, DANIEL R.
3 WEST GARDEN STREET
SUITE 344
PENSACOLA FL 32501

10. Name and Address of New Registered Agent

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 _____ (Typed or printed name of registered agent and title if applicable) (Typed or printed name of registered agent signing) DATE

12. OFFICERS AND DIRECTORS	13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12
TITLE: D NAME: TIMMONS, RUBEN B. M.D. STREET ADDRESS: ~~POST OFFICE BOX 9320~~ 4412 N DAVIS Hwy CITY-ST-ZIP: PENSACOLA, FL 32503	11 TITLE ☐ Change ☐ Addition 12 NAME 13 STREET ADDRESS 14 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	21 TITLE ☐ Change ☐ Addition 22 NAME 23 STREET ADDRESS 24 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	31 TITLE ☐ Change ☐ Addition 32 NAME 33 STREET ADDRESS 34 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	41 TITLE ☐ Change ☐ Addition 42 NAME 43 STREET ADDRESS 44 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	51 TITLE ☐ Change ☐ Addition 52 NAME 53 STREET ADDRESS 54 CITY-ST-ZIP
TITLE NAME STREET ADDRESS CITY-ST-ZIP	61 TITLE ☐ Change ☐ Addition 62 NAME 63 STREET ADDRESS 64 CITY-ST-ZIP

14. I hereby certify that the information contained with this form is voluntarily furnished and 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, added or deleted.

SIGNATURE: X Ruben Timmons MD X 2-14-95 X 904-434-7824
SIGNATURE AND TYPED OR PRINTED NAME OF MANAGING OFFICER OR DIRECTOR — DATE — DAYTIME PHONE

CP