

2015 FLORIDA PROFIT CORPORATION ANNUAL REPORT

DOCUMENT# 601793

Entity Name: ANESTHESIA ASSOCIATES, M.D., P.A.**Current Principal Place of Business:**567 AVENUE K S.E.
WINTER HAVEN, FL 33880**Current Mailing Address:**567 AVENUE K S.E.
WINTER HAVEN, FL 33880**FEI Number:** 59-1278346**Certificate of Status Desired:** No**Name and Address of Current Registered Agent:**LINGENFELTER, ALAN L
567 AVENUE K S.E.
WINTER HAVEN, FL 33880 US*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**Officer/Director Detail :**

Title STD
Name OTTAIANO, DOMENIC V MD
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

Title VD
Name PUIG, ENRIQUE MD
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

Title PD
Name LINGENFELTER, ALAN L MD
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

Title VD
Name ECKERT, JORDAN W MD
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

Title VD
Name MYERS, WILLIAM P M.D.
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

Title VD
Name DRUM, JERRY BJR, MD
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

Title VD
Name KENAN, CHARBEL A MD
Address 567 AVENUE K S.E.
City-State-Zip: WINTER HAVEN FL 33880

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: LINGENFELTER , ALAN L MD

PD

01/13/2015

Electronic Signature of Signing Officer/Director Detail_____
Date