

**2025 FLORIDA PROFIT CORPORATION ANNUAL REPORT**

DOCUMENT# F81078

**Entity Name:** WEST FLORIDA MEDICAL CENTER CLINIC, P.A.

**Current Principal Place of Business:**

8333 NORTH DAVIS HIGHWAY  
PENSACOLA, FL 32514

**Current Mailing Address:**

8333 NORTH DAVIS HIGHWAY  
PENSACOLA, FL 32514 US

**FEI Number:** 59-2193856

**Certificate of Status Desired:** No

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

BRANNING, JEREMY C  
125 E. INTENDENCIA STREET, 4TH FLOOR  
PENSACOLA, FL 32502 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 EXECUTIVE DIRECTOR  
Name POPPLE, M. A  
Address 8333 NORTH DAVIS HWY  
City-State-Zip: PENSACOLA FL 32514

Title CEO  
Name MURRAY, M.D., JENNIFER  
Address 8333 NORTH DAVIS HWY  
City-State-Zip: PENSACOLA FL 32514

Title PRESIDENT  
Name WELCH, M.D., KEVIN  
Address 8333 NORTH DAVIS HWY  
City-State-Zip: PENSACOLA FL 32514

Title SECRETARY  
Name NAVAS, M.D., LUIS  
Address 8333 NORTH DAVIS HIGHWAY  
City-State-Zip: PENSACOLA FL 32514

Title VP  
Name KIRBY, M.D., BRIAN  
Address 8333 N DAVIS HWY  
City-State-Zip: PENSACOLA FL 32514

*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:** M.A.POPPLE

**EXECUTIVE DIRECTOR**

**04/18/2025**

\_\_\_\_\_  
Electronic Signature of Signing Officer/Director Detail

\_\_\_\_\_  
Date