

2013 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**FEI Number:** 59-2193856**Certificate of Status Desired:** No**Name and Address of Current Registered Agent:**HUSTON, GARY W
125 W ROMANA STREET
SUITE 800
PENSACOLA, FL 32501 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	EVP
Name	POPPLE, M. A
Address	8333 NORTH DAVIS HWY
City-State-Zip:	PENSACOLA FL 32514

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

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

Title	VP
Name	SCHMITZ, MARCUS M.D.
Address	8333 NORTH DAVIS HIGHWAY
City-State-Zip:	PENSACOLA FL 32514

Title	ST
Name	JONES, DEREK M.D.
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: KEVIN WELCH

PRESIDENT

04/23/2013

Electronic Signature of Signing Officer/Director Detail_____
Date