

2014 FLORIDA PROFIT CORPORATION ANNUAL REPORT

DOCUMENT# H64028

Entity Name: DERMATOLOGY ASSOCIATES OF TALLAHASSEE, P.A.**Current Principal Place of Business:**1707 RIGGINS RD
TALLAHASSEE, FL 32308**Current Mailing Address:**P O BOX 13859
TALLAHASSEE, FL 32317 US**FEI Number:** 59-2524839**Certificate of Status Desired:** Yes**Name and Address of Current Registered Agent:**COGNETTA, ARMAND BMD
1707 RIGGINS RD
TALLAHASSEE, FL 32308 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	PT
Name	ARMAND B. COGNETTA, MD
Address	1707 RIGGINS RD
City-State-Zip:	TALLAHASSEE FL 32308

Title	VPT
Name	GORDON J. LOW, MD
Address	1714 MAHAN CENTER BLVD
City-State-Zip:	TALLAHASSEE FL 32308

Title	SECRETARY
Name	BHAVIK P. SONI, MD
Address	1707 RIGGINS ROAD
City-State-Zip:	TALLAHASSEE FL 32308

Title	TREASURER
Name	STEPHEN K. RICHARDSON, MD
Address	1714 MAHAN CENTER BLVD
City-State-Zip:	TALLAHASSEE FL 32309

Title	ASST. SECRETARY
Name	DAVID J. DOLSON, MD
Address	P O BOX 13859
City-State-Zip:	TALLAHASSEE FL 32317

Title	ASST. TREASURER
Name	MARC J. INGLESE, MD
Address	P O BOX 13859
City-State-Zip:	TALLAHASSEE FL 32317

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: ARMAND B. COGNETTA, M.D.

M.D. / PRESIDENT

01/08/2014

Electronic Signature of Signing Officer/Director Detail_____
Date