

August 1, 1996

Merrill Sharp, M.D.
M. J. Sharp, M.D. C44240
330 S 7th Ave
Pocatello ID 83201

RE: M. J. Sharp, M.D. C44240

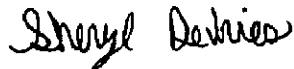
Greetings:

Please find enclosed your recently submitted annual report for the 1996-1997 fiscal year. We are unable to accept it in its present form. Please make the following correction(s) and return to this office.

- 1) Block 4 must show complete names and addresses of all officers.
- 2) The annual report must be signed by an authorized individual designated by the Board of the corporation.

If you have any questions or need further assistance, please do not hesitate to contact this office at (208) 332-2811.

Very truly yours,



Sheryl DeVries
Corporate Division

Enclosures: cited

No. C 44240	Annual Report Form 1996 <i>Due No Later Than November 30,</i>		2. Registered Agent and Office NOT A P.O. BOX																																																																			
Return to: SECRETARY OF STATE 700 WEST JEFFERSON PO BOX 83720 BOISE, ID 83720-0080 NO FEE REQUIRED * FIRST NOTICE *	1. Mailing Address - Please Correct, If Not Correct M. J. SHARP, M.D., P.A. MERRILL J. SHARP, M.D. 240 N. 18TH 330 S. 7th Ave POCATELLO ID 83201		M. J. SHARP, M.D. 240 N. 18TH AVE. POCATELLO ID 83201 3. Organized Under the Laws of: ID C 44240																																																																			
4. Corporations: Enter Names and Addresses of President, Secretary and Directors Limited Liability Companies: Enter Names and Addresses of <input type="checkbox"/> Managers or <input type="checkbox"/> Members (check one) <table border="1"> <thead> <tr> <th>Office held</th> <th>Name</th> <th>Street or P.O. Address</th> <th>City</th> <th>State</th> <th>Zip</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>					Office held	Name	Street or P.O. Address	City	State	Zip																																																												
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5. NATURE OF BUSINESS MEDICAL		6. I certify that this Annual Report has been examined by me and is to the best of my knowledge true, correct and complete. Signature _____ Date _____ Name (Typed or Printed) _____ Title _____																																																																				

ISSUED: 07-06-1996

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