

No. C 73045	Annual Report Form 19 96 <i>Due No Later Than November 30,</i>		2. Registered Agent and Office NOT A P.O. BOX MICHAEL K. PARENT 307 ST. JOHN'S WAY LEWISTON ID 83501
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		3. Organized Under the Laws of: ID C 73045
	MICHAEL K. PARENT, M.D., P.A. MICHAEL K. PARENT 307 ST. JOHN'S WAY LEWISTON ID 83501		
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)			
<u>Office held</u> <u>Name</u> <u>Street or P.O. Address</u> <u>City</u> <u>State</u> <u>Zip</u>			
<div style="display: flex; justify-content: space-between;"> <div style="width: 15%;"> <u>President</u> <u>Secretary</u> </div> <div style="width: 40%;"> <u>MICHAEL PARENT MD</u> <u>Patricia Smith</u> </div> <div style="width: 45%;"> <u>307 St John's way</u> <u>307 St John's way</u> </div> <div style="width: 15%;"> <u>Lewiston Idaho</u> <u>Lewiston Idaho</u> </div> <div style="width: 10%;"> <u>83501</u> <u>83501</u> </div> </div>			
5. NATURE OF BUSINESS MEDICAL PRACTICE	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 <u>Michael K Parent MD</u> Date <u>7/15/96</u> Name (Typed or Printed) <u>MICHAEL K. PARENT</u> Title <u>President</u>		

ISSUED: 07-06-1996

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