

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Jul 14, 2003 8:00 am**  
**Secretary of State**

07-14-2003 90171 009 \*\*\*550.00

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**DOCUMENT # 493131**

1. Entity Name  
**INFECTIOUS DISEASE CONSULTANTS, M.D., P.A.**



Principal Place of Business  
**685 PALM SPGS DR #2A  
PALM SPRINGS MEDICAL CENTER  
ALTAMONTE SPRINGS FL 32701**

Mailing Address  
**685 PALM SPGS DR #2A  
PALM SPRINGS MEDICAL CENTER  
ALTAMONTE SPRINGS FL 32701**



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

CHECK HERE IF MAKING CHANGES

City & State

City & State

4. FEI Number **59-1634257**

Applied For  
 Not Applicable

Zip

Country

Zip

Country

5. Certificate of Status Desired  **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**RUIZ, CARLOS J.  
685 PALM SPGS DR #2A  
ALTAMONTE SPRINGS FL 32701**

Name

Street Address (P.O. Box Number is Not Acceptable)

City

**FL**

Zip Code

8. 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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$550.00**

**After September 10, 2003 Fee will be \$750.00  
Make Check Payable to Florida Department of State**

9. Election Campaign Financing  
Trust Fund Contribution.

**\$5.00** May Be  
Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	VP	<input type="checkbox"/> Delete
NAME	<b>RUIZ, CARLOS J</b>	
STREET ADDRESS	<b>685 PALM SPGS DR #2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRGS, FL00000</b>	
TITLE	P	<input type="checkbox"/> Delete
NAME	<b>CARRIZOSA, JAIME</b>	
STREET ADDRESS	<b>685 PALM SPGS DR #2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRGS, FL00000</b>	
TITLE	T	<input type="checkbox"/> Delete
NAME	<b>SANCHEZ, PHILLIP M</b>	
STREET ADDRESS	<b>685 PALM SPRINGS DR, STE 2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRINGS FL</b>	
TITLE	S	<input type="checkbox"/> Delete
NAME	<b>DE JESUS, EDWIN M</b>	
STREET ADDRESS	<b>685 PALM SPRINGS DR, STE 2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRINGS FL</b>	
TITLE	D	<input type="checkbox"/> Delete
NAME	<b>COOPER, TIMOTHY</b>	
STREET ADDRESS	<b>685 PALM SPRINGS DR #2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRINGS FL 32701</b>	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

TITLE	DIRECTOR	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	<b>Fernando Alvarado, M.D</b>	
STREET ADDRESS	<b>685 PALM SPRINGS DR #2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRINGS, FL 32701</b>	
TITLE	DIRECTOR	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	<b>JASON SHIFFEN, D.O.</b>	
STREET ADDRESS	<b>685 PALM SPRINGS DR #2A</b>	
CITY-ST-ZIP	<b>ALTAMONTE SPRINGS, FL 32701</b>	
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my 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 in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: **SIGNATURE REQUIRED** *Phillip M Sanchez, MD* 7-7-03 407 830 9927  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (4/03)