2000 UNIFORM BUSINESS REPORT (UBR)

FILED
May 12, 2000 8:00 am
Secretary of State
05-12-2000 90075 011 ***150.00

DOCUMENT # 600266

1. Entity Name

DOCTORS MCCLOW, CLARK & BERK, P.A.

Principal Place of Business	Mailing Address
DEPT.OF RADIOLOGY ST. VINCENT'S HOSPITAL BOX 10128 JACKSONVILLE FL 32247	DEPT.OF RADIOLOGY ST. VINCENT'S HOSPITAL BOX 10128 JACKSONVILLE FL 32247-0128

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. FEI Number 59-1162456 ☐ Applied For ☐ Not Applicable

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
GIFFORD, ROGER D 1800 BARRS ST DEPT OF RADIOLOGY, ST VINCENT'S HOSP JACKSONVILLE FL 32204	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.

SIGNATURE _____
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) ☐

FILE NOW!!! FEE IS $150.00
After MAY 1, 2000 Fee will be $550.00
Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

11. OFFICERS AND DIRECTORS			12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	S DONOHUE, MICHAEL T ST. VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	DIR ANTHONY TOLEDO ST. VINCENTS HOSPITAL JAX	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	AT LUIS-JORGE, JUAN C ST VINCENTS HOSPITAL JACKSONVILLE, FL 00000	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	2ND VP CARTER, MARK M. ST.VINCENTS HOSPITAL JACKSONVILLE, FLA.	☐ Change ☒ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	T FREEMAN, MARC H ST VINCENT'S HOSP JACKSONVILLE FL 32204	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	VP BREAM, PETER ST. VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	P GIFFORD, ROGER D. ST. VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D BANCROFT, JOSIAH W III ST VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition

CR2E034 (9/99)

13. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), 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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: [signature] FILED ROGER D. GIFFORD, PRESIDENT 4/26/00 904-388-1562
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #