

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 07, 2001 8:00 am
Secretary of State

02-07-2001 90161 020 ***150.00

DOCUMENT # 603636

1. Entity Name
RICHEY MEDICAL CENTER, INC.

Principal Place of Business 5341 GRAND BOULEVARD NEW PORT RICHEY FL 34652	Mailing Address 5341 GRAND BOULEVARD NEW PORT RICHEY FL 34652
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DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address		4. FEI Number 59-1400611		Applied For	
Suite, Apt. #, etc.		Suite, Apt. #, etc.				Not Applicable	
City & State		City & State		5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	
Zip	Country	Zip	Country				

6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent							
SCHYLER, ARTHUR M MD 5341 GRAND BOULEVARD NEW PORT RICHEY FL 34652				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 _____ (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) <input type="checkbox"/>	FILE NOW!!! FEE IS \$150.00 After MAY 1, 2001 Fee will be \$550.00 Make Check Payable to Department of State	10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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11. OFFICERS AND DIRECTORS				12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11			
TITLE	ST	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	P J GONZALEZ M.D.			NAME			
STREET ADDRESS	5341 GRAND BOULEVARD			STREET ADDRESS			
CITY-ST-ZIP	NEW PORT RICHEY FL			CITY-ST-ZIP			
TITLE	P	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	ARTHUR M SCHLYER M.D.			NAME			
STREET ADDRESS	5341 GRAND BLVD.			STREET ADDRESS			
CITY-ST-ZIP	NEW PORT RICHEY FL			CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			

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: Arthur M. Schlyer, M.D. Pres. Date 2/2/01 727 848-3439
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Daytime Phone #

CR2E034 (10/00)