

# 2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # H60345

1. Entity Name

CENTER FOR INFERTILITY AND REPRODUCTIVE MEDICINE

**FILED**  
**Mar 03, 2000 8:00 am**  
**Secretary of State**

03-03-2000 90194 047 \*\*\*150.00

|                                                                        |                                                                 |
|------------------------------------------------------------------------|-----------------------------------------------------------------|
| Principal Place of Business<br>3435 PINEHURST AVE.<br>ORLANDO FL 32804 | Mailing Address<br>3435 PINEHURST AVE.<br>ORLANDO FL 32804-4049 |
|------------------------------------------------------------------------|-----------------------------------------------------------------|

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



DO NOT WRITE IN THIS SPACE

|                                                           |  |                                |
|-----------------------------------------------------------|--|--------------------------------|
| 4. FEI Number 59-2542546                                  |  | Applied For                    |
|                                                           |  | Not Applicable                 |
| 5. Certificate of Status Desired <input type="checkbox"/> |  | \$8.75 Additional Fee Required |

|                                                                                                                         |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 6. Name and Address of Current Registered Agent<br><br>DEVANE, GARY W., M.D.<br>3435 PINEHURST AVE.<br>ORLANDO FL 32804 | 7. Name and Address of New Registered Agent<br>Name<br>Street Address (P.O. Box Number is Not Acceptable)<br>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. <input type="checkbox"/> (See criteria on back) | <b>FILE NOW!!! FEE IS \$150.00</b><br><b>After MAY 1, 2000 Fee will be \$550.00</b><br><b>Make Check Payable to Department of State</b> | 10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|

| 11. OFFICERS AND DIRECTORS                     |                                                                                             | 12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 |                                                                   |
|------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------|
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | PD<br>DEVANE, GARY W.<br>1035 LAKEVIEW DR<br>WINTER PARK FL <input type="checkbox"/> Delete | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | ST<br>LOY, RANDALL A<br>3435 PINEHURST AVE<br>ORLANDO FL <input type="checkbox"/> Delete    | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete                                                             | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete                                                             | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete                                                             | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete                                                             | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |

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 REQUIRED 25 FEB 2000 (407) 740-0909

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/99)