

2000 UNIFORM BUSINESS REPORT (UBR)

APPROVED
AND
FILED

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

8/4/12



DO NOT WRITE IN THIS SPACE

DOCUMENT # L98000003270	
1. Entity Name PATHOLOGY ASSOCIATES OF NORTH FLORIDA, P.L.	
Principal Place of Business 6500 WEST NEWBERRY ROAD GAINESVILLE FL 32605	Mailing Address P.O. BOX 147006 GAINESVILLE FL 32614-7006
2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip	Country

4. FEI Number 59-3548179	APPLIED FOR X	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>		\$5.00 Additional Fee Required

6. Name and Address of Current Registered Agent		7. Name and Address of New Registered Agent	
BYERS, GEORGE E P.A. 6500 WEST NEWBERRY ROAD GAINESVILLE FL 32605		Name PATRICIA W. GOLDBLATT, MD, PA Street Address (P.O. Box Number is Not Acceptable) PO BOX 147006 City GAINESVILLE FL Zip Code 32614-7006	

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 *Patricia Goldblatt, M.D.*
George E. Byers, Jr., M.D., P.A. **George E. BYERS, JR. M.D. P.A. (MGRM) 3-10-2000**

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

FILE NOW!!! FEE IS \$50.00
Make Check Payable to Department of State

9. MANAGING MEMBERS/MEMBERS		10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM GEORGE E. BYERS, M.D., P.A. P.O. BOX 147006 GAINESVILLE FL 32614-7006 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM PATRICIA W. GOLDBLATT, M.D., P.A. P.O. BOX 147006 GAINESVILLE FL 32614-7006 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM SALLY E. RYDEN, M.D., P.A. P.O. BOX 147006 GAINESVILLE FL 32614-7006 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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11. 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 is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE *George E. Byers, Jr., M.D., P.A. (MGRM)* **George E. BYERS, JR. M.D. P.A. (MGRM)**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER OR MANAGER
Date **3-10-2000** Daytime Phone # **(352) 378-0379**

CR2E083 (9/99)