

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 01, 2002 8:00 am
Secretary of State

04-04-2002 90086 021 ****50.00

DOCUMENT # L98000003270

1. Entity Name

PATHOLOGY ASSOCIATES OF NORTH FLORIDA, P.L.

Principal Place of Business

Mailing Address

6500 WEST NEWBERRY ROAD
 GAINESVILLE FL 32605

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

Zip

Country

4. FEI Number

59-3548179

Applied For

Not Applicable

5. Certificate of Status Desired

\$5.00 Additional
 Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

GOLDBLATT, PATRICIA W MD, PA
 P.O. BOX 147006
 GAINESVILLE FL 32614-7006

Name **Goldblatt Patricia W, MD, PA**
 Street Address (P.O. Box Number is Not Acceptable)
North Florida Regional Medical Center
6500 West Newberry Road
 City **Gainesville, FL** Zip Code **FL 32606**

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

FILE NOW!!! FEE IS \$50.00
Make Check Payable to Department of State
Due By May 1, 2002

9. MANAGING MEMBERS/MANAGERS

10. ADDITIONS/CHANGES

TITLE NAME **MGRM PATRICIA W. GOLDBLATT, M.D., P.A.** Delete
 STREET ADDRESS **P.O. BOX 147006**
 CITY-ST-ZIP **GAINESVILLE FL 32614-7006**

TITLE NAME Change Addition
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME **MGRM SALLY E. RYDEN, M.D., P.A.** Delete
 STREET ADDRESS **P.O. BOX 147006**
 CITY-ST-ZIP **GAINESVILLE FL 32614-7006**

TITLE NAME Change Addition
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME **MGRM** Delete
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME **MGRM Troy A. Hampton, M.D., P.A.** Change Addition
 STREET ADDRESS **P.O. Box 147006**
 CITY-ST-ZIP **Gainesville, FL 32614-7006**

TITLE NAME Delete
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME Change Addition
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME Delete
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME Change Addition
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME Delete
 STREET ADDRESS
 CITY-ST-ZIP

TITLE NAME Change Addition
 STREET ADDRESS
 CITY-ST-ZIP

11. 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 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:

Patricia Goldblatt M.D.

4-22-02

3/30/02

352-333-4955

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

CR2E083 (9/01)