

# 2003 LIMITED LIABILITY COMPANY UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 14, 2003 8:00 am**  
**Secretary of State**

04-14-2003 90002 007 \*\*\*\*50.00

0049708

**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

4. FEI Number **59-3548179**

Applied For  
Not Applicable

Zip

Country

Zip

Country

5. Certificate of Status Desired  **\$5.00 Additional Fee Required**

CHECK HERE IF MAKING CHANGES



6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**GOLDBLATT, PATRICIA W MD, PA  
NORTH FLORIDA REGIONAL MEDICAL CENTER  
6500 WEST NEWBERRY ROAD  
GAINESVILLE FL 32605**

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE \_\_\_\_\_ (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

**FILE NOW!!! FEE IS \$50.00**  
**Make Check Payable to Florida Department of State**  
**Due By May 1, 2003**

9. MANAGING MEMBERS/MANAGERS

10. ADDITIONS/CHANGES

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

TITLE NAME  Change  Addition  
STREET ADDRESS  
CITY-ST-ZIP

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

TITLE NAME  Change  Addition  
STREET ADDRESS  
CITY-ST-ZIP

TITLE NAME  Delete  
**MGRM HAMPTON, TROY A MD, PA**  
STREET ADDRESS  
**PO BOX 147086**  
CITY-ST-ZIP  
**GAINESVILLE FL 32614-7006**

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

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)(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 of the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE: *Patricia W. Goldblatt, M.D., P.A.*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

Date **4/10/03** Daytime Phone #

CR2E083 (10/02)