

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 29, 2002 8:00 am
Secretary of State

05-29-2002 90707 034 ****61.25

0059564

DOCUMENT # N93000005451

1. Entity Name

BERT FISH MEDICAL CENTER FOUNDATION, INC.

Principal Place of Business

Mailing Address

**401 PALMETTO STREET
 NEW SMYRNA BEACH FL 32168**

**P.O. BOX 1000
 NEW SMYRNA BEACH FL 32170**

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: **59-3219250**

Applied For: Not Applicable

5. Certificate of Status Desired **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**HEEKIN, JAMES F JR
 215 N EOLA DRIVE
 ORLANDO FL 32802**

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

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

FILE NOW: FEE IS \$61.25

9. Election Campaign Financing Trust Fund Contribution.

\$5.00 May Be Added to Fees

Make Check Payable to Department of State

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE NAME STREET ADDRESS CITY-ST-ZIP	D CLOWER, KAY W 128 SAND PINE PLACE NEW SMYRNA BCH FL 32168	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D FABER, CHERYL 448 QUAY ASSISI NEW SMYRNA BEACH FL 32169	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D JONES, HUGH 508 THIRD AVE NEW SMYRNA BCH FL 32169	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DC POULIN, KEN 801 MAGNOLIA STREET NEW SMYRNA BCH FL 32168	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D ALCORN, THOMAS 240 GOLF CLUB DR NEW SMYRNA BEACH FL 32168	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D PRESTON, WILLIAM 143 CANAL STREET NEW SMYRNA BCH FL 32168	<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"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DC Nelson Jones 304 DeSoto Drive New Smyrna Bch FL 32168	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D Bob Hercnel 418 Quay Assisi New Smyrna Bch FL 32169	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. 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 617, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: *Robert A. [Signature]* **REQUIRED**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E037 (9/01)



DO NOT WRITE IN THIS SPACE