

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 24, 2002 8:00 am
Secretary of State

03-24-2002 90025 032 ****61.25

DOCUMENT # N96000005806

1. Entity Name

THE CERTIFYING COMMISSION IN MEDICAL MANAGEMENT, INC.

Principal Place of Business

Mailing Address

**4890 W KENNEDY BLVD
 SUITE 200
 TAMPA FL 33609**

**4890 W KENNEDY BLVD
 SUITE 200
 TAMPA FL 33609**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number

31-1487805

Applied For

Not Applicable

Zip

Country

Zip

Country

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

**SCHENKE, ROGER S
 4890 W KENNEDY BLVD
 SUITE 200
 TAMPA FL 33609**

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]
 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	CD RANDOLPH, ME GIN LEONARD JR 110 LUKE AVE, STE 500 BOLLING AFB DC 20332-7050	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ECD SCHENKE, ROGER S 4890 W. KENNEDY BLVD., STE 200 TAMPA, FL 33609	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	STD VCD CASANOVA, JAMES DR MEDICAL COLLIER OF WI PKY CLINICS BROOKFIELD WI 53045-5020	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VCD CD HICKY, D. MARTIN LOVELACE NLTH SYS. 5400 GIBSON BLVD SE ALBUQUERQUE NM 87108	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	STD Ransom, Scott B. Wayne State Univ. School of Med. Detroit, MI 48301	<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		<input type="checkbox"/> Change <input 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:

[Signature]
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E037 (9/01)



DO NOT WRITE IN THIS SPACE