

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P94000068901

1. Entity Name:

ATLANTIC SURGERY CENTER, INC.

FILED
Mar 27, 2000 8:00 am
Secretary of State

03-27-2000 90114 001 ***150.00

Principal Place of Business 541 HEALTH BLVD DAYTONA BEACH FL 32114	Mailing Address 541 HEALTH BLVD DAYTONA BEACH FL 32114-1493
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2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



DO NOT WRITE IN THIS SPACE

4. FEI Number 59-3282460		Applied For
		Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent M.Z. REGISTERED AGENT CORP. 2601 S BAYSHORE DR SUITE 1600 MIAMI FL 33133	7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code
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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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) <input type="checkbox"/>	FILE NOW!!! FEE IS \$150.00 After MAY 1, 2000 Fee will be \$550.00 Make Check Payable to Department of State	10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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11. OFFICERS AND DIRECTORS		12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D BROWN, B. T MD 602 RIVERSIDE DR ORMOND BEACH FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	Director Michael A. Munier, MD 45 Shadow Creek Way Ormond Beach, FL 32174 <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD WESCOTT, JOHN W. M 89 N. ST. ANDREWS DR. ORMOND BEACH FL <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	D CANTWELL, ANTHONY L MD 25 FOREST VIEW WAY ORMAND BEACH FL 32174 <input checked="" 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	D MCDONOUGH, MICHAEL W. D 595 W. GRANADA AVE. ORMOND BEACH FL <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	D WILLIAMS, ROBERT MD 704 OVERLOOK TRAIL PORT ORANGE FL 32119 <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

13. 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 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: John W. Wescott, MD, President 3-21-00 904-239-850

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #