

**2003 FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**

FILED
May 01, 2003 8:00 am
Secretary of State

05-01-2003 90248 046 ***150.00

0289661 AV

DOCUMENT # P95000091524

1. Entity Name
HS1 MEDICAL MANAGEMENT, INC.



Principal Place of Business
**1505 NW 167 STREET
SUITE 450
MIAMI FL 33169**

Mailing Address
**1505 NW 167 STREET
SUITE 450
MIAMI FL 33169**



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number **65-0622851**

Applied For
Not Applicable

Zip

Country

Zip

Country

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

CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**LEAHY, ROBERT J
1505 NW 167 STREET
SUITE 450
MIAMI FL 33169**

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

**FILE NOW!!! FEE IS \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State**

9. Election Campaign Financing Trust Fund Contribution. **\$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD LEAHY, ROBERT 1505 NW 167 STREET SUITE 450 MIAMI FL 33169	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VDT KEARNEY, KRISTIN 1505 NW 167 STREET SUITE 450 MIAMI FL 33169	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	SD DALBERRY, DEAN 1505 NW 167 STREET SUITE 450 MIAMI FL 33169	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DV WILHELM, CHARLES MD 1505 NW 167 STREET SUITE 450 MIAMI FL 33169	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
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
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	DVS WILHELM, CHARLES, MD 1505 N.W. 167 STREET SUITE 450 MIAMI, FL 33169	<input checked="" 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 607, 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 Leahy **RECEIVED LEAHY** 4.24.03 305.614.0100
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/02)