

**2002 UNIFORM BUSINESS REPORT (UBR)**

**FILED**  
**Mar 03, 2002 8:00 am**  
**Secretary of State**  
 03-03-2002 90060 011 \*\*\*150.00

0161326  
AV

**DOCUMENT # P97000031541**  
 1. Entity Name  
**HOMESTEAD MEDICAL GROUP, INC.**

Principal Place of Business <b>950 N. KROME AVE. SUITE 203 HOMESTEAD FL 33030</b>	Mailing Address <b>950 N. KROME AVE. SUITE 203 HOMESTEAD FL 33030</b>
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2. Principal Place of Business Suite, Apt. #, etc.	3. Mailing Address Suite, Apt. #, etc.
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DO NOT WRITE IN THIS SPACE

City & State	City & State	4. FEI Number <b>65-0753565</b>	Applied For <input type="checkbox"/> Not Applicable
Zip	Country	Zip	Country

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

**6. Name and Address of Current Registered Agent**

**PENA, HERIBERTO M.D.**  
**950 N. KROME AVE, SUITE 203**  
**HOMESTEAD FL 33030**

**7. Name and Address of New Registered Agent**

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 \_\_\_\_\_ DATE \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating)

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so.   
 (See criteria on back)

**FILE NOW!!! FEE IS \$150.00**  
**After May 1, 2002 Fee will be \$550.00**  
**Make Check Payable to Department of State**

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

**11. OFFICERS AND DIRECTORS**

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>PSD PENA, MYRNA 950 N. KROME AVE, SUITE 203 HOMESTEAD FL 33030</b>	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>VPTD PENA, HERIBERTO 950 N. KROME AVE, SUITE 203 HOMESTEAD FL 33030</b>	<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"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

**12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11**

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

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:** *Heriberto Peña, MD* 2/15/02 305-245-2273  
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/01)