

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 16, 2001 8:00 am
Secretary of State

04-16-2001 90007 043 ***150.00

DOCUMENT # P97000080121

1. Entity Name
CENTRAL FLORIDA PHYSICIANS NETWORK, INC.

Principal Place of Business 500 EAST CENTRAL AVENUE WINTER HAVEN FL 33880	Mailing Address 500 EAST CENTRAL AVENUE WINTER HAVEN FL 33880
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DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address		4. FEI Number 59-3515394	Applied For
Suite, Apt. #, etc.		Suite, Apt. #, etc.			Not Applicable
City & State		City & State		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
Zip	Country	Zip	Country		

6. Name and Address of Current Registered Agent RUNGE, ANDREW 500 EAST CENTRAL AVENUE WINTER HAVEN FL 33880			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. <input checked="" type="checkbox"/> (See criteria on back)	FILE NOW!!! FEE IS \$150.00 After MAY 1, 2001 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	D <input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	CARIFI, VINCENT G MD		NAME		
STREET ADDRESS	500 EAST CENTRAL AVENUE		STREET ADDRESS		
CITY-ST-ZIP	WINTER HAVEN FL 33880		CITY-ST-ZIP		
TITLE	D <input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	BERGNES, JOSEPH A M.D.		NAME		
STREET ADDRESS	635 1ST STREET NORTH		STREET ADDRESS		
CITY-ST-ZIP	WINTER HAVEN FL 33880		CITY-ST-ZIP		
TITLE	D <input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	INMAN, CHARLES C MD		NAME		
STREET ADDRESS	500 EAST CENTRAL AVENUE		STREET ADDRESS		
CITY-ST-ZIP	WINTER HAVEN FL 33880		CITY-ST-ZIP		
TITLE	D <input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	MCGETRICK, JOHN J MD		NAME		
STREET ADDRESS	635 FIRST ST. NORTH		STREET ADDRESS		
CITY-ST-ZIP	WINTER HAVEN FL 33880		CITY-ST-ZIP		
TITLE	<input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE	<input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		

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: _____ DATE: 4/3/01 DAYTIME PHONE #: 863-293-1191
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

CR2E034 (10/00)