

# 2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P98000058388

1. Entity Name

SURGERY CENTER OF OKEECHOBEE, INC.

FILED

Jan 26, 2000 8:00 am  
Secretary of State

01-26-2000 90004 012 \*\*\*150.00

100400



DO NOT WRITE IN THIS SPACE

Principal Place of Business 1655 HIGHWAY 441 NORTH OKEECHOBEE FL 34972 US	Mailing Address 245 N.E. 19TH DRIVE OKEECHOBEE FL 34972-1933
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2. Principal Place of Business	3. Mailing Address
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Suite, Apt. #, etc.	Suite, Apt. #, etc.
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City & State	City & State
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Zip	Country	Zip	Country
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4. FEI Number 65-0847931	Applied For <input type="checkbox"/> Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
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6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

RAPPEL, ROBERT  
2770 INDIAN RIVER BLVD.  
SUITES 314/315  
VERO BEACH FL 32960-4230

Name RAPPEL, ROBERT
Street Address (P.O. Box Number is Not Acceptable) 5070 HWY A1A - NORTH - SUITE 221
RAPPEL + RAPPEL
City VERO BEACH FL 32963-1216

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
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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, 2000 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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD LANZA, JOHN M.D. 200 19TH DRIVE OKEECHOBEE FL 34972	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	STD JAMES, RICHARD M.D. 245 19TH DRIVE OKEECHOBEE FL 34972	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D CHANG, JOHN M.D. 235 N.E. 19TH DRIVE OKEECHOBEE FL 34972	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D KURESHI, ZAFAR M.D. 214 N.E. 19TH DRIVE OKEECHOBEE FL 34972	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D GARCIA, MANUEL M.D. 306 N.E. 19TH DRIVE OKEECHOBEE FL 34972	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D LEVINE, MARC M.D. P.O. BOX 494H DRIVE OKEECHOBEE FL 34972	<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
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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:	SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR JOHN LANZA M.D.	Date 1/11/00	Daytime Phone # 941-357-6220
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CR2E034 (9/99)