

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 11, 2003 8:00 am
Secretary of State

04-11-2003 90221 028 ***150.00

DOCUMENT # P98000058388



1. Entity Name
SURGERY CENTER OF OKEECHOBEE, INC.

Principal Place of Business
**1655 HIGHWAY 441 NORTH
OKEECHOBEE FL 34972
US**

Mailing Address
**245 N.E. 19TH DRIVE
OKEECHOBEE FL 34972-1933**



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number **65-0847931**

Applied For
Not Applicable

CHECK HERE IF MAKING CHANGES

Zip Country

Zip Country

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

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**RAPPEL, ROBERT
5070 HWY A1A - STE 221
C/O RAPPEL & RAPAEL
VERO BEACH FL 32960-4230**

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

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 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 checked="" 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
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

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: **X SIGNATURE REGISTERED** **4/8/03** **863-357-6220**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/02)