

N97000003941

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP     WAIT     MAIL

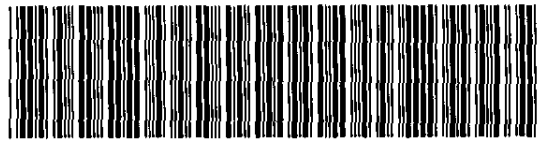
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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R. WHITE

MAR 16 2018

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18 MAR 15 AM 7:59

DEPARTMENT OF STATE  
ACCOUNT FILING COVER SHEET

Account Number FCA000000017  
Date: 3-15-18  
Requestor Name: Carlton Fields  
Address: Post Office Drawer 190  
Tallahassee, Florida 32302  
Telephone: (850) 513-3619 - direct  
(850) 224-1585  
Contact Name: Kim Pullen, CP, FRP

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DEPARTMENT OF STATE  
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Corporation Name: Florida Health Sciences Center,  
\_\_\_\_\_  
Email Address: \_\_\_\_\_  
Entity Number: 197000003941  
Authorization: Kim Pullen

\_\_\_\_ Certified Copy

\_\_\_\_ New Filings

\_\_\_\_ Fictitious Name

Plain Stamped Copy

Amendments  
Statement of Change

\_\_\_\_ Certificate of Stat

\_\_\_\_ Annual Report

\_\_\_\_ Registration

Call When Ready

Call if Problem

After 4:30

Walk In

Will Wait

Pick Up

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\_\_\_\_\_  
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- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Certified Copy  | <input checked="" type="checkbox"/> Plain Stamped Copy         | <input type="checkbox"/> Certificate of Status |
| <input type="checkbox"/> New Filings     | <input checked="" type="checkbox"/> Amendments                 | <input type="checkbox"/> Annual Report         |
| <input type="checkbox"/> Fictitious Name | <input checked="" type="checkbox"/> <u>Statement of Change</u> | <input type="checkbox"/> Registration          |

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Call When Ready | <input checked="" type="checkbox"/> Call if Problem | <input type="checkbox"/> After 4:30         |
| <input checked="" type="checkbox"/> Walk In         | <input type="checkbox"/> Will Wait                  | <input checked="" type="checkbox"/> Pick Up |

**STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT OR BOTH FOR CORPORATIONS**

Pursuant to the provisions of sections 607.0502, 617.0502, 607.1508, or 617.1508, Florida Statutes, this statement of change is submitted for a corporation organized under the laws of the State of Florida in order to change its registered office or registered agent, or both, in the State of Florida.

1. The name of the corporation: Florida Health Sciences Center, Inc.  
2. The principal office address: One Tampa General Circle, Tampa, FL 33606  
3. The mailing address (if different): \_\_\_\_\_  
4. Date of incorporation/qualification: 07/09/1997 Document number: N97000003941

5. The name and street address of the current registered agent and registered office on file with the Florida Department of State: (If resigned, enter resigned)

Amarily Torres  
Tampa General Hospital, One Tampa General Circle  
Tampa, FL 33606


6. The name and street address of the new registered agent (if changed) and /or registered office (if changed):

Jonathan Dixon, III, Esq.  
One Davis Blvd., Suite 401  
P.O. Box NOT acceptable  
Tampa, FL 33606

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FILED

The street address of its registered office and the street address of the business office of its registered agent, as changed will be identical.

Such change was authorized by resolution duly adopted by its board of directors or by an officer so authorized by the board, or the corporation has been notified in writing of the change.

  
\_\_\_\_\_  
Signature of an officer or director

John D. Couris, President  
\_\_\_\_\_  
Printed or typed name and title

*I hereby accept the appointment as registered agent and agree to act in this capacity, I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligation of my position as registered agent. Or, if this document is being filed merely to reflect a change in the registered office address, I hereby confirm that the corporation has been notified in writing of this change.*

  
\_\_\_\_\_  
Signature of Registered Agent

March 9, 2018  
\_\_\_\_\_  
Date

If signing on behalf of an entity:  
Jonathan Dixon III  
\_\_\_\_\_  
Typed or Printed Name

\*\*\* FILING FEE: \$35.00 \*\*\*