

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 09, 2003 8:00 am
Secretary of State

04-09-2003 90134 043 ***150.00

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DOCUMENT # 600266

1. Entity Name

DOCTORS MCCLOW, CLARK & BERK, P.A.



Principal Place of Business

Mailing Address

DEPT.OF RADIOLOGY
ST. VINCENT'S HOSPITAL BOX 10128
JACKSONVILLE FL 32247

DEPT.OF RADIOLOGY
ST. VINCENT'S HOSPITAL BOX 10128
JACKSONVILLE FL 32247

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number

59-1162456

Applied For

Not Applicable

5. Certificate of Status Desired

☐ \$8.75 Additional Fee Required

☐ CHECK HERE IF MAKING CHANGES



6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

GIFFORD, ROGER D
1800 BARRS ST
DEPT OF RADIOLOGY, ST VINCENT'S HOSP
JACKSONVILLE FL 32204

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

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

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 1

TITLE NAME STREET ADDRESS CITY-ST-ZIP	S DONOHUE, MICHAEL T ST. VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	AT LUIS-JORGE, JUAN C ST VINCENTS HOSPITAL JACKSONVILLE, FL 00000	☐ Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T FREEMAN, MARC H ST VINCENT'S HOSP JACKSONVILLE FL 32204	☐ Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP BREAM, PETER ST. VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P GIFFORD, ROGER D. ST. VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D BANCROFT, JOSIAH W III ST VINCENTS HOSPITAL JACKSONVILLE FL	☐ Delete

TITLE NAME STREET ADDRESS CITY-ST-ZIP	Director Toledo, Anthony S. St. Vincents Hospital Jacksonville, Fla. 32204	☐ Change ☒ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	Director Shill, Ronald S. St. Vincents Hospital Jacksonville, Fla. 32204	☐ Change ☒ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	Director Punn, Joseph L. St. Vincents Hospital Jacksonville, Fla. 32204	☐ Change ☒ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ 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:

SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

4-7-03

CR2E034 (10/02)