

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

8/1

FILED
Sep 03, 2003 8:00 am
Secretary of State

08-18-2003 90164 037 ***550.00

DOCUMENT # 600557

1. Entity Name
**GILMER, COX, BOTT & TORRES ORTHOPAEDIC ASSOCIATI
ON, P.A.**



Principal Place of Business
**2881 SOUTH DELANEY AVENUE
BOX 568288
ORLANDO FL 32856-5288**

Mailing Address
**2881 SOUTH DELANEY AVENUE
BOX 568288
ORLANDO FL 32856-5288**

55055604

2. Principal Place of Business
546 Osceola Commerce Pkwy

3. Mailing Address
546 Osceola Commerce Pkwy

Suite, Apt. #, etc.

Suite, Apt. #, etc.

☒ CHECK HERE IF MAKING CHANGES

City & State
Osceola, FL

City & State
Osceola, FL

4. FEI Number **59-1227093**

Applied For
☐ Not Applicable

Zip
34761

Country
USA

Zip
34761

Country
USA

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

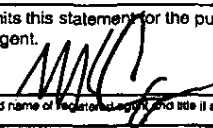
6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**COX, WILLIAM K M.D.
2881 S DELANEY AVENUE
ORLANDO FL 32806**

Name **W. KEVIN COX, M.D.**
Street Address (P.O. Box Number is Not Acceptable)
546 Osceola Commerce PARKWAY
City **Osceola** FL Zip Code **34761**

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 re-registering)

8-27-03
DATE

FILE NOW!!! FEE IS \$550.00
After September 10, 2003 Fee will be \$750.00
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 **T** ☐ Delete
NAME **COX, WILLIAM S**
STREET ADDRESS **3019 CULLEN LAKESHORE DR**
CITY-ST-ZIP **ORLANDO FL**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

P ☐ Delete
NAME **COX, KEVIN W.**
STREET ADDRESS **17311 MAGNOLIA ISLAND BLVD.**
CITY-ST-ZIP **CLERMONT FL 37411**

TITLE ☒ Change ☐ Addition
NAME **PRESIDENT**
STREET ADDRESS **COX, W. KEVIN**
CITY-ST-ZIP **17311 MAGNOLIA ISLAND BLVD.**
CLERMONT, FL 37411

VP ☐ Delete
NAME **BOTT, WILLIAM K**
STREET ADDRESS **2605 NELA AVENUE**
CITY-ST-ZIP **ORLANDO FL 32809-3172**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

S ☐ Delete
NAME **TORRES, JOSE A M.D.**
STREET ADDRESS **7548 PARK SPRING CIR**
CITY-ST-ZIP **ORLANDO FL 32835**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

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: Kevin Cox, M.D.

Date

Daytime Phone #

CR2E034 (4/03)