

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Jan 15, 2003 8:00 am
Secretary of State

01-15-2003 90172 026 ***150.00

DOCUMENT # F58761

1. Entity Name
ROBERT C. KLINE, M.D., P.A.



Principal Place of Business
312 PONCE DE LEON BLVD
BELLEAIR FL 33756
US

Mailing Address
312 PONCE DE LEON BLVD
BELLEAIR FL 33756
US

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

☐ CHECK HERE IF MAKING CHANGES

4. FEI Number **59-2147897**

Applied For
Not Applicable

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

KLINE, ROBERT C
312 PONCE DE LEON BLVD
CLEARWATER FL 33756

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 11

TITLE **DPT** ☐ Delete
NAME **KLINE, ROBERT C, MD**
STREET ADDRESS **312 PONCE DE LEON BLVD**
CITY-ST-ZIP **BELLEAIR FL 33756**

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

TITLE **S** ☐ Delete
NAME **KLINE, ROBERT C, MD**
STREET ADDRESS **312 PONCE DE LEON BLVD**
CITY-ST-ZIP **BELLEAIR FL 33756**

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

TITLE **AT** ☐ Delete
NAME **KLINE, MOLLY A**
STREET ADDRESS **312 PONCE DE LEON BLVD**
CITY-ST-ZIP **BELLEAIR FL 33756**

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

TITLE **DV** ☐ Delete
NAME **HART, MARY B MD**
STREET ADDRESS **1256 DRUID RD S**
CITY-ST-ZIP **BELLEAIR FL 33756**

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

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

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

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ 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, 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:

Robert C. Kline MD
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (10/02)