

2001 UNIFORM BUSINESS REPORT (UBR)

FILED

May 05, 2001 8:00 am
Secretary of State

05-05-2001 90282 001 *****8.75
05-05-2001 90282 002 ***150.00

DOCUMENT # **G20646**

1. Entity Name

CHARLOTTE DENTAL ASSOCIATES, P.A.

Principal Place of Business

**2595 HARBOR BLVD., STE. 109
PORT CHARLOTTE FL 33952**

Mailing Address

**2595 HARBOR BLVD., STE. 109
PORT CHARLOTTE FL 33952**

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 **59-2249925**

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

**WATTERS, JOHN L., II, D.M.D.
2595 HARBOR BLVD., STE. 109
PORT CHARLOTTE FL 33952**

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.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

9. This corporation is eligible to satisfy its Intangible
Tax filing requirement and elects to do so.
(See criteria on back) ☐

**FILE NOW!!! FEE IS \$150.00
After MAY 1, 2001 Fee will be \$550.00
Make Check Payable to Department of State**

10. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P WATTERS, JOHN L., II 293 FRY TERR. PORT CHARLOTTE FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VS BENDER, JOSEPH C. 2303 KENYA LANE PORT CHARLOTTE FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T LOUSCHER, BERT G. 2216 CASSINO CT. PUNTA GORDA FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<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
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

13. 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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

John L. Watters, DMD
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

4/24/01 (941) 625-2908

CR2E034 (10/00)