

2000 UNIFORM BUSINESS REPORT (UBR)

FILED
May 18, 2000 8:00 am
Secretary of State

05-18-2000 90307 003 ***150.00

DOCUMENT # G65346

1. Entity Name
PHYSICIANS' MEDICAL SERVICES OF JACKSONVILLE, IN

Principal Place of Business

Mailing Address

BELFORT RD
JACKSONVILLE FL 32216

4201 BELFORT RD
JACKSONVILLE FL 32216-1431
US

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 **59-2369228**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

READ, J LARRY
4201 BELFORT ROAD
JACKSONVILLE FL 32216

7. Name and Address of New Registered Agent

Name **Joanne L Martin**

Street Address (P.O. Box Number is Not Acceptable)

4500 San Pablo Road

City **Jacksonville**

FL

Zip Code

32224

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

4/26/00

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, 2000 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	T	<input type="checkbox"/> Delete
NAME	HOCKING, DALE E	
STREET ADDRESS	4201 BELFORT RD	
CITY-ST-ZIP	JACKSONVILLE FL	
TITLE	P	<input type="checkbox"/> Delete
NAME	HERRELL, JOHN H	
STREET ADDRESS	200 SW 1ST ST	
CITY-ST-ZIP	ROCHESTER MN	
TITLE	C	<input checked="" type="checkbox"/> Delete
NAME	BLACK, LEO F., M.D.	
STREET ADDRESS	4500 SAN PABLO RD.	
CITY-ST-ZIP	JACKSONVILLE FL	
TITLE	S	<input type="checkbox"/> Delete
NAME	HUBER, HAROLD	
STREET ADDRESS	4201 BELFORT RD	
CITY-ST-ZIP	JACKSONVILLE FL	
TITLE	VC	<input type="checkbox"/> Delete
NAME	WALTERS, ROBERT M	
STREET ADDRESS	4500 SAN PABLO RD	
CITY-ST-ZIP	JACKSONVILLE FL	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE	C	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	Denis A. Cortese, M.D.	
STREET ADDRESS	4500 San Pablo Rd.	
CITY-ST-ZIP	Jacksonville FL	
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

4/26/00

904-953-2400

CR2E034 (9/99)