

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Jul 18, 2001 8:00 am
Secretary of State

06-12-2001 90002 020 ***150.00
 07-18-2001 90257 043 ***400.00

DOCUMENT # J19144			
1. Entity Name HOSPITAL MEDICAL STAFF SELF-INSURANCE TRUST, INC			
Principal Place of Business C/O AON RISK SERVICES, INC. OF FLORIDA 1001 BRICKELL BAY DR., SUITE 1100 MIAMI FL 33131		Mailing Address C/O AON RISK SERVICES, INC. OF FLORIDA 1001 BRICKELL BAY DR., SUITE 1100 MIAMI FL 33131	
2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent AON RISK SERVICES, INC. OF FLORIDA 1001 BRICKELL BAY DR. SUITE 1100 MIAMI FL 33131		7. Name and Address of New Registered Agent	
		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 _____ (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) <input type="checkbox"/>	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. <input type="checkbox"/> \$5.00 Ma Added to Fe
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11. OFFICERS AND DIRECTORS		12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 1	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	ST ALDRICH, JOSE J. 2645 SW 37TH AVE. MIAMI FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/>
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D BAXTER, ALAN J 10261 SW 128 ST MIAMI FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/>
TITLE NAME STREET ADDRESS CITY - ST - ZIP	C SCHEINER, MONROE L. 9000 CORAL REEF DR. MIAMI FL <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY - ST - ZIP	<input type="checkbox"/> Change <input type="checkbox"/>
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"/>
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"/>
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"/>

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 changed, or on an attachment with an address, with all other like information.

SIGNATURE: _____
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

6/5/2001 (305) 8-57
 Daytime Phone #