

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 17, 2003 8:00 am**  
**Secretary of State**

04-17-2003 90634 021 \*\*\*150.00

**DOCUMENT # J77571**

1. Entity Name  
**SOUTHEASTERN INTEGRATED MEDICAL, P.A.**



Principal Place of Business  
**4881 NW 8 AVE.  
SUITE 2  
GAINESVILLE FL 32605  
US**

Mailing Address  
**P.O. BOX 357010  
GAINESVILLE FL 32635  
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 **59-2819741**

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

**DEPAZ, OSCAR B M.D.  
4881 NW 8TH AVE  
STE 2  
GAINESVILLE FL 32607**

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 **DP** ☐ Delete  
NAME **DEPAZ, OSCAR B**  
STREET ADDRESS **4881 NW 8 AVE., STE 2**  
CITY-ST-ZIP **GAINESVILLE FL 32605**

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

TITLE **S** ☐ Delete  
NAME **HUNTER, OREGON K**  
STREET ADDRESS **4881 NW 8TH AVE STE 2**  
CITY-ST-ZIP **GAINESVILLE FL 32605**

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

TITLE **S** ☐ Delete  
NAME **PUENTE-GUZMAN, RIGOBERTO M.D.**  
STREET ADDRESS **4881 NW 8TH AVE #2**  
CITY-ST-ZIP **GAINESVILLE FL 32605**

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

TITLE **D** ☐ Delete  
NAME **LIPNICK, JESSE MD**  
STREET ADDRESS **4881 NW 8TH AVENUE #2**  
CITY-ST-ZIP **GAINESVILLE FL 32605**

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

TITLE **D** ☐ Delete  
NAME **LEBER, CHRISTOPHER MD**  
STREET ADDRESS **4881 NW 8TH AVENUE #2**  
CITY-ST-ZIP **GAINESVILLE FL 32605**

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

TITLE **D** ☐ Delete  
NAME **Newcomer, Gary MD**  
STREET ADDRESS **4881 NW 8th Avenue #2**  
CITY-ST-ZIP **Gainesville, FL 32605**

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 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 empowerments.

SIGNATURE:

**SIGNATURE REQUIRED**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**4/16/03**

Date

Daytime Phone #

CR2E034 (10/02)