

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Feb 07, 2003 8:00 am**  
**Secretary of State**

02-07-2003 90051 042 \*\*\*158.75

**DOCUMENT # K03002**

1. Entity Name  
**ST. JOSEPH'S PHYSICIAN ASSOCIATES, INC.**



Principal Place of Business  
P. O. BOX 151526  
TAMPA FL 33684-8526

Mailing Address  
P. O. BOX 151526  
TAMPA FL 33684-8526



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number **59-2858209**

Applied For  
Not Applicable

Zip

Country

Zip

Country

5. Certificate of Status Desired ☒ **\$8.75 Additional Fee Required**

☐ CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**CERNUDA, CHARLES E., M.D.**  
**4900 N. HABANA AVE**  
**TAMPA FL 33614**

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 **TD** ☐ Delete  
NAME **MANISCALCO, BENEDICT**  
STREET ADDRESS **2727 W MLK JR BLVD STE 800**  
CITY-ST-ZIP **TAMPA FL 33607**

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

TITLE **VD** ☐ Delete  
NAME **LURIA, WILLIAM M.D.**  
STREET ADDRESS **2727 W. MLKING JR. BLVD. SUITE 500**  
CITY-ST-ZIP **TAMPA FL 33607**

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

TITLE **PD** ☐ Delete  
NAME **MILLER, ALLEN M.D.**  
STREET ADDRESS **4612 N. HABAN AVE SUITE 203**  
CITY-ST-ZIP **TAMPA FL 33614**

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

TITLE **D** ☐ Delete  
NAME **CERNUDA, CHARLES**  
STREET ADDRESS **4900 N. HABANA AVE.**  
CITY-ST-ZIP **TAMPA FL**

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

TITLE **CD** ☐ Delete  
NAME **EDGERTON W. BRUCE**  
STREET ADDRESS **2706 W. DR. M.L. KING JR. BLVD, SUITE A**  
CITY-ST-ZIP **TAMPA FL**

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

TITLE **SD** ☐ Delete  
NAME **ANGEL, DOLOLOO MD**  
STREET ADDRESS **4503 N ARMENIA AVE**  
CITY-ST-ZIP **TAMPA FL 33603**

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 empowered.

SIGNATURE:

*SINAGRE*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (10/02)