

# 2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # K03039

1. Entity Name

FIG HEALTHCARE, INC.

**FILED**  
**Feb 24, 2000 8:00 am**  
**Secretary of State**

02-24-2000 90003 031 \*\*\*150.00

Principal Place of Business

16800 NW 2ND AVENUE  
SUITE 502  
MIAMI FL 33169-2587  
US

Mailing Address

16800 NW 2ND AVENUE  
SUITE 502  
MIAMI FL 33169-5549  
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

65-0022961

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

FIGUEROA, MIGUEL  
16800 NW 2ND AVENUE  
SUITE 502  
MIAMI FL 33169-2587

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, 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	PD	<input type="checkbox"/> Delete
NAME	FIGUEROA, MIGUEL	
STREET ADDRESS	16800 NW 2ND AVE #502	
CITY-ST-ZIP	MIAMI FL	
TITLE	VD	<input type="checkbox"/> Delete
NAME	BHASKARAN, THOTTANKARA	
STREET ADDRESS	16800 NW 2ND AVENUE #502	
CITY-ST-ZIP	MIAMI FL	
TITLE	SD	<input type="checkbox"/> Delete
NAME	ZAHN, EDMUND K. MD	
STREET ADDRESS	16800 NW 2ND AVENUE #502	
CITY-ST-ZIP	MIAMI FL	
TITLE	TD	<input type="checkbox"/> Delete
NAME	PAL, JAIME L., MD	
STREET ADDRESS	16800 NW 2ND AVENUE #502	
CITY-ST-ZIP	MIAMI FL	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
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		
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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)(f), 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 #

(305) 651-3444

CR2E034 (9/99)