

# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 20, 2000 8:00 am**  
**Secretary of State**

04-20-2000 90068 023 \*\*\*150.00

**DOCUMENT # K43086**

1. Entity Name

**THE PROGRAM WORKSHOP, INC.**

Principal Place of Business % WILLIAM H. GRANT, III 859 PARK AVE. STE-104 ORANGE PARK FL 32073	Mailing Address % WILLIAM H. GRANT, III 859 PARK AVE. STE-104 ORANGE PARK FL 32073-4151
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2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip	Country

4. FEI Number	54-1310979	Applied For	<input type="checkbox"/>
		Not Applicable	<input type="checkbox"/>
5. Certificate of Status Desired	<input type="checkbox"/>	\$8.75 Additional Fee Required	



DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent <b>GRANT, WILLIAM H., III</b> <b>859 PARK AVE.</b> <b>SUITE 104</b> <b>ORANGE PARK FL 32073</b>	7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <b>FL</b> Zip Code
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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 \_\_\_\_\_ DATE \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) <input type="checkbox"/>	<b>FILE NOW!!! FEE IS \$150.00</b> <b>After MAY 1, 2000 Fee will be \$550.00</b> <b>Make Check Payable to Department of State</b>	10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00 May Be Added to Fees</b>
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11. OFFICERS AND DIRECTORS		12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	<b>D</b> <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	<b>SANDERS, MICHAEL C., MD</b>	NAME	
STREET ADDRESS	<b>301 HEALTH PARK BLVD.</b>	STREET ADDRESS	
CITY-ST-ZIP	<b>ST. AUGUSTINE FL</b>	CITY-ST-ZIP	
TITLE	<b>D</b> <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	<b>SANDERS, MARYANNE J.</b>	NAME	
STREET ADDRESS	<b>301 HEALTH PARK BLVD.</b>	STREET ADDRESS	
CITY-ST-ZIP	<b>ST. AUGUSTINE FL</b>	CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		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:** **7-16-00 (904) 829-**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #  
**MICHAEL C. SANDERS, MD.**