

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)


**FILED**  
**Jan 15, 2003 8:00 am**  
**Secretary of State**

01-15-2003 90277 013 \*\*\*150.00

MACTER AVI

**DOCUMENT # K56591**

1. Entity Name  
**TAMPA NEUROLOGY ASSOCIATES, P.A.**



Principal Place of Business  
**2919 SWANN AVE. STE 401  
TAMPA FL 33609**

Mailing Address  
**2919 SWANN AVE. STE 401  
TAMPA FL 33609**



2. Principal Place of Business  
Suite, Apt. #, etc.

3. Mailing Address  
Suite, Apt. #, etc.

CHECK HERE IF MAKING CHANGES

City & State

4. FEI Number **59-2919747**

Applied For  
 Not Applicable

Zip Country

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

**6. Name and Address of Current Registered Agent**

**RUGG, JOSEPH**  
**201 N FRANKLIN ST**  
**SUITE 2100**  
**TAMPA FL 33602**

**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. 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**

TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>SERGAY, STEPHEN M., M.D.</b>	
STREET ADDRESS	<b>2919 SWANN AVE #401</b>	
CITY-ST-ZIP	<b>TAMPA FL</b>	
TITLE	<b>DVS</b>	<input type="checkbox"/> Delete
NAME	<b>STEEN, SUSAN J., M.D.</b>	
STREET ADDRESS	<b>2919 SWANN AVE #401</b>	
CITY-ST-ZIP	<b>TAMPA FL</b>	
TITLE	<b>PAS</b>	<input type="checkbox"/> Delete
NAME	<b>SERGAY, STEPHEN M., M.D.</b>	
STREET ADDRESS	<b>2919 SWANN AVE #401</b>	
CITY-ST-ZIP	<b>TAMPA FL</b>	
TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>CASCIONE, MARK M.D.</b>	
STREET ADDRESS	<b>2919 SWANN AVE #401</b>	
CITY-ST-ZIP	<b>TAMPA FL</b>	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

**11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11**

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		
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		

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:** SIGNATURE REQUIRED **1-15-03 812-875-5199**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/02)