

# 2001 UNIFORM BUSINESS REPORT (UBR)

0002838 AF

**DOCUMENT #** L00000002028  
**1. Entity Name**  
 JOAN D. O'LEARY, M.D., P.L.

FILED  
 01 APR 27 AM 2:13

SECRETARY OF STATE  
 TALLAHASSEE, FLORIDA



DO NOT WRITE IN THIS SPACE

**Principal Place of Business** 12143 DIVIDING OAKS TRAIL EAST JACKSONVILLE FL 32223  
**Mailing Address** 12143 DIVIDING OAKS TRAIL EAST JACKSONVILLE FL 32223

**2. Principal Place of Business**  
 1406 Kingsley Ave.  
 Suite, Apt. #, etc. Orange Park, FL.  
 City & State 32073  
 Zip Country USA  
**3. Mailing Address**  
 Suite, Apt. #, etc.  
 City & State  
 Zip Country

**4. FEI Number** 59-3626152 Applied For Not Applicable  
**5. Certificate of Status Desired**  \$5.00 Additional Fee Required

**6. Name and Address of Current Registered Agent**  
 O'LEARY, WILLIAM A ESQ.  
 1301 RIVERPLACE BLVD.  
 SUITE 1500  
 JACKSONVILLE FL 32207

**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.**  
 SIGNATURE *Joan D. O'Leary* Joan D. O'Leary, M.D. P.L. DATE 4.22.01  
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

**FILE NOW!!! FEE IS \$50.00**  
 Make Check Payable to Department of State

9. MANAGING MEMBERS / MEMBERS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete

10. ADDITIONS / CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	manager. Joan D. O'Leary, M.D. 12143 Dividing Oaks Tr. E Jacksonville, FL. 32223 <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	500004211525--8 -05/11/01--01060--016 *****50.00 *****50.00 <input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

**11. 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 is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.**

**SIGNATURE:** *Joan D. O'Leary* JOAN D. O'Leary M.D. 904-278-3100  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #

CR2E083 (11/00)