

2001 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # L00000008525

1. Entity Name

Point of Care Clinics Surgery, LLC

FILED

01 JUN 20 AM 11:11

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business
1001 Livingston Road
Lutz, FL 33549

Mailing Address
1001 Livingston Road
Lutz, FL 33549

2. Principal Place of Business
38021 Market Square

3. Mailing Address
4805 W. Laurel Street

DO NOT WRITE IN THIS SPACE

Suite, Apt. #, etc.

Suite, Apt. #, etc.
Suite 100

City & State
Zephyrhills, FL

City & State
Tampa, FL

4. FEI Number
59-3659216

Applied For
Not Applicable

Zip
33540

Country
USA

Zip
33607

Country
USA

5. Certificate of Status Desired ☐

\$5.00 Additional Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

Mikos, Cynthia A. Esquire
Cynthia A. Mikos, PA
205 N. Parsons Ave, Suite A
Brandon, FL 33510-4515

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

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

9. MANAGING MEMBERS/MANAGERS

10. ADDITIONS/CHANGES

TITLE MGR ☐ Delete
NAME Hasan Farid Hashmi, MD Inc.
STREET ADDRESS 1001 Livingston Road
CITY - ST - ZIP Lutz, FL 33549

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

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY - ST - ZIP

TITLE ☐ Change ☐ Addition
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CITY - ST - ZIP

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

Date

Daytime Phone #

CR2E083 (11/00)