

# 2001 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # L00000015741

1. Entity Name

FILED

01 APR 23 PM 4:10

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DADE COUNTY EMERGENCY PEDIATRICS, LLC

Principal Place of Business

Mailing Address

2828 CROSDAILE DRIVE  
DURHAM, NC 27705

2. Principal Place of Business

3. Mailing Address

P.O. Box 15309

Suite, Apt. #, etc.

Suite, Apt. #, etc.

DO NOT WRITE IN THIS SPACE

City & State

City & State

DURHAM NC

4. FEI Number

56-1836488

Applied For

Not Applicable

Zip

Country

Zip

27705

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

CT CORPORATION  
1200 SOUTH PINE ISLAND ROAD  
PLANTATION, FL 33324

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

400004138394--0

--05/07/01--01047--014

\*\*\*\*\*50.00 \*\*\*\*\*50.00

9. MANAGING MEMBERS / MEMBERS

10. ADDITIONS / CHANGES

TITLE MEMBER/MANAGER ☐ Delete  
NAME PEDIATRIC CONSULTANTS OF BROWARD COUNTY INC.  
STREET ADDRESS 2828 CROSDAILE DRIVE  
CITY-ST-ZIP DURHAM, NC 27705

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

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

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

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Change ☐ Addition  
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TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
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: SHERMAN M. PODOLSKY M.D.

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

4/12/01

Date

954-942-6700

Daytime Phone #

CR2E083 (11/00)