

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 12, 2002 8:00 am
Secretary of State

05-12-2002 90600 043 ***150.00

DOCUMENT # L11160

1. Entity Name

HABANA MEDICAL CENTER, INC.

Principal Place of Business

**4700 N. HABANA AVENUE
 STE 602
 TAMPA FL 33614**

Mailing Address

**4700 N. HABANA AVENUE
 STE 602
 TAMPA FL 33614**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number

59-2970216

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75 Additional
 Fee Required**

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

KINSOLVING, LAURENCE E

% CARLTON, FIELDS, WARD, EMMANUEL

ONE HARBOUR PLACE

TAMPA FL 33602

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

9. This corporation is eligible to satisfy its intangible tax filing requirement and elects to do so. (See criteria on back) ☐

FILE NOW!!! FEE IS: \$150.00

After May 1, 2002 Fee will be \$550.00

Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. ☐

**\$5.00 May Be
 Added to Fees**

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P WOOD, GARY L PSY.D. 4700 N HABANA AVE # TAMPA FL 33614 <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VPD DIACO, JOSEPH F MD 4700 N. HABANA AVE., #403 TAMPA FL 33614 <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	SD BRANNAN, ANTHONY N MD 4700 N. HABANA AVE. #201 TAMPA FL 33614 <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"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

GARY L WOOD PsyD

4-15-2002

813-872-8794

Date

Daytime Phone #

CR2E034 (9/01)