

FILED
May 07, 2002 8:00 am
Secretary of State
05-07-2002 90264 014 ***150.00

1. Entity Name
DONALD B. WILLIAMS, M.D., P.A.

Mailing Address

% DONALD B. WILLIAMS. M.D.
4300 ALTON RD (MT SINAI MEDICAL CENTER)
MIAMI BEACH FL 33140

3. Mailing Address

Suite, Apt. #, etc.

City & State

Country

Not Applicable

7

\$8.75 Additional
Fee Required

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, 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, 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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
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NAME _____ ☐ Change ☐ Addition

STREET ADDRESS

CITY-ST-ZIP

0111 01 01

TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME		

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.

Donald B. Williams

Date _____

Daytime Phone #

CR2E034 (9/01)