

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
May 01, 2003 8:00 am
Secretary of State

05-01-2003 90817 004 ***150.00

05669697 AV

DOCUMENT # L43917

1. Entity Name
GULFCOAST PAIN MEDICINE CENTER, INC.



Principal Place of Business
~~21220 OLEAN BLVD #D~~
~~FT CHARLOTTE FL 33052~~
~~US~~

Mailing Address
P O BOX 5309
SARASOTA FL 34277-5309
US



2. Principal Place of Business

3. Mailing Address

PO Box 924

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

West Palm Beach FL

Zip

Country

Zip

Country

33402

USA

4. FEI Number **65-0164436**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

☒ CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

ORENS, SCOTT
3945 HAMILTON CLUB CIRCLE
SARASOTA FL 34242

Name **Scott S. Orens**

Street Address (P.O. Box Number is Not Acceptable)

255 Evernia St

City **West Palm Beach**

FL

Zip Code **33401**

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. I am familiar with, and accept the obligations of registered agent.

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 \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **P** ☐ Delete
NAME **ORENS, SCOTT**
STREET ADDRESS **4801 S. UNIVERSITY DR. STE 303**
CITY-ST-ZIP **FORT LAUDERDALE FL 33328**

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

TITLE ☐ Delete
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CITY-ST-ZIP

TITLE ☐ Change ☐ Addition
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CITY-ST-ZIP

12. 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 10 or Block 11 if changed, or on an attachment with an address, and all other like empowered.

SIGNATURE:

Scott S. Orens **5/29/03**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (10/02)

attachment

80102347
#L43917

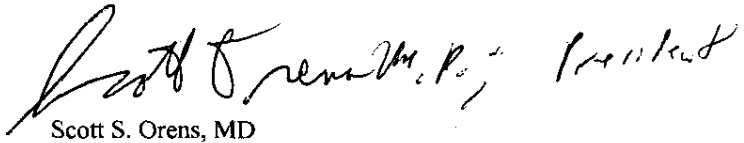
Annual Report Gulfcoast Pain Medicine Center

March 3, 2003

Gulfcoast Pain Medicine Center

This is to confirm that any business has been discussed with the members of the Board of Directors. Any old business (please see last years report submitted with last renewal application) was concluded at that time.

Respectfully yours,

President

Scott S. Orens, MD
President