

# 2001 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # **L94000000094**

1. Entity Name

**IMMOKALEE FAMILY DOCTOR'S CLINIC, L.C.**

FILED

01 APR 30 PM 5:24

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

Principal Place of Business

**1501 B. SIXTH AVE.  
IMMOKALEE FL 33934**

Mailing Address

**1501 B. SIXTH AVE.  
IMMOKALEE FL 33934**

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

**65-0469967**

Applied For

Not Applicable

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

**PUERTO, JUAN R DR.  
1501 B. SIXTH AVE.  
IMMOKALEE FL 33934**

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/MEMBERS

10. ADDITIONS/CHANGES

TITLE ☐ Delete  
NAME **MGRM**  
STREET ADDRESS **PUERTO, JUAN R DR.**  
CITY-ST-ZIP **1501 B. SIXTH AVE.  
IMMOKALEE FL 33934**

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

TITLE ☐ Delete  
NAME **MGRM**  
STREET ADDRESS **PUERTO, CAROL**  
CITY-ST-ZIP **1501 B. SIXTH AVE.  
IMMOKALEE FL 33934**

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

TITLE ☐ Delete  
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STREET ADDRESS  
CITY-ST-ZIP

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:

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

Date

Daytime Phone #

CR2E083 (11/00)

00303065  
IN



DO NOT WRITE IN THIS SPACE

**MJH**

**4000004220354-3**  
**-05/16/01--01087--023**  
**\*\*\*\*\*50.00 \*\*\*\*\*50.00**

**4/24/01 9416572779**