

2000 UNIFORM BUSINESS REPORT (UBR)

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

00 MAR 16 PM 1:55

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DOCUMENT # L94000000731

1. Entity Name
BAYONET POINT/HUDSON MEDICAL CENTER PHO, L.C.

Principal Place of Business Mailing Address
BAYONET POINT/HUDSON MEDICAL CENTER BAYONET POINT/HUDSON MEDICAL CENTER
14000 FIVAY ROAD 14000 FIVAY ROAD
HUDSON FL 34667 HUDSON FL 34667-7103

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 59-3326465 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

MILLER, DANIEL
BAYONET POINT/HUDSON MEDICAL CENTER
14000 FIVAY ROAD
HUDSON FL 34667

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 NAME STREET ADDRESS CITY-ST-ZIP	MGR TAYLOR, WAYNE MD 13906 LAKESHORE BLVD 330 HUDSON FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR MUSUNURU, RAO MD 14100 FIVAY RD, SUITE 160 NEW PORT RICHEY FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR KUMAR, K S MD 5802 S.R. 54 NEW PORT RICHEY FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR ACEVEDO, PABLO MD 5307 MAIN STREET, SUITE 104 NEW PORT RICHEY FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR KULKARNI, GAJANAN MD 5802 S.R. 54 DRIVE NEW PORT RICHEY FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGR ERWIN, JACKLIEN MD 12843 US HIGHWAY 19 HUDSON FL	<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

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 REQUIRED 3/9/00 727-8425414
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER OR MANAGER Date Daytime Phone #

CR2E083 (9/99)