

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # L98000000014

1. Entity Name  
CYPRESS DELRAY MEDICAL, L.C.

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS  
00 FEB -7 AM 10:39

Principal Place of Business  
6646 WEST ATLANTIC AVENUE  
DELRAY BEACH FL 33446

Mailing Address  
6646 WEST ATLANTIC AVENUE  
DELRAY BEACH FL 33446-1616



2. Principal Place of Business  
Suite, Apt. #, etc.  
City & State  
Zip Country

3. Mailing Address  
Suite, Apt. #, etc.  
City & State  
Zip Country

DO NOT WRITE IN THIS SPACE

4. FEI Number 65-0809598  
Applied For  
Not Applicable

5. Certificate of Status Desired ☐ \$5.00 Additional Fee Required

6. Name and Address of Current Registered Agent  
SABATES, GEORGE L  
6646 W. ATLANTIC AVENUE, 3RD FLOOR  
DELRAY BEACH FL 33446

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  
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

TITLE NAME STREET ADDRESS CITY- ST- ZIP	MGRM DELRAY MEDICAL ASSOCIATES, INC. 6646 WEST ATLANTIC AVENUE DELRAY BEACH FL 33446	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY- ST- ZIP	MGRM CYPRESS CREEK MEDICAL CENTER INC. 912 N.E. 62ND STREET FORT LAUDERDALE FL 33334	<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

10. ADDITIONS/CHANGES

TITLE NAME STREET ADDRESS CITY- ST- ZIP	600003140786-3 -02/21/00--01018--020 *****50.00 *****50.00	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY- ST- ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY- ST- ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY- ST- ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER OR MANAGER  
Date 1-17-2000 Daytime Phone # 561-637-4125

0008902 AF  
CR2E083 (9/99)