# 2002 UNIFORM BUSINESS REPORT (UBR)

4.

**FILED**
**May 01, 2002 8:00 am**
**Secretary of State**
04-04-2002 90086 021 ****50.00

DOCUMENT # L98000003270

1. Entity Name

PATHOLOGY ASSOCIATES OF NORTH FLORIDA, P.L.

| Principal Place of Business | Mailing Address |
|---|---|
| 6500 WEST NEWBERRY ROAD<br>GAINESVILLE FL 32605 | P.O. BOX 147006<br>GAINESVILLE FL 32614-7006 |

DO NOT WRITE IN THIS SPACE

| 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 59-3548179 ☐ 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 |
|---|---|
| GOLDBLATT, PATRICIA W MD, PA<br>P.O. BOX 147006<br>GAINESVILLE FL 32614-7006 | Name: Goldblatt, Patricia W., M.D., P.A.<br>Street Address (P.O. Box Number is Not Acceptable): c/o North Florida Regional Medical Center<br>6500 West Newberry Road<br>City: Gainesville, FL **FL** Zip Code: 32605 |

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**
**Due By May 1, 2002**

| 9. MANAGING MEMBERS/MANAGERS | | | 10. ADDITIONS/CHANGES | | |
|---|---|---|---|---|---|
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | MGRM<br>PATRICIA W. GOLDBLATT, M.D., P.A.<br>P.O. BOX 147006<br>GAINESVILLE FL 32614-7006 | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | MGRM<br>SALLY E. RYDEN, M.D., P.A.<br>P.O. BOX 147006<br>GAINESVILLE FL 32614-7006 | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | MGR | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | MGRM<br>Troy A. Hampton, MD, PA<br>PO Box 147006<br>Gainesville, FL 32614-7006 | ☐ Change ☒ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
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CR2E083 (9/01)

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.

4-22-02

**SIGNATURE:** Patricia W. Goldblatt MD 3/30/02 352 333-4955
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #