

# 2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # L99000004692

1. Entity Name

ALLIED HEALTHCARE PROFESSIONALS OF FLORIDA, L.L.

Principal Place of Business

5124 CALLE MINORGA  
SARASOTA FL 34242

Mailing Address

5124 CALLE MINORGA  
SARASOTA FL 34242

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS

00 AUG 10 AM 10:02



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number

Applied For

Not Applicable

Zip

Country

Zip

Country

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

BUCKHANNON, ROBERT L

5124 CALLE MINORGA

SARASOTA FL 34242

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/MANAGERS

10. ADDITIONS/CHANGES

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
MGR  
ALLIED HEATHCARE PROFESSIONALS, INC.  
5124 CALLE MINORGA  
SARASOTA FL 34242 ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
000003359470--6  
-08/16/00--01064--013  
\*\*\*\*\*50.00 \*\*\*\*\*50.00 ☐ Change ☐ Addition

TITLE  
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CITY-ST-ZIP ☐ Change ☐ 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 AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER OR MANAGER

Date

Daytime Phone #

CR2E083 (5/00)