

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # M98652

1. Entity Name

WEST COAST PATHOLOGY OF FLORIDA, P.A.

FILED
Mar 08, 2000 8:00 am
Secretary of State

03-08-2000 90018 041 ***150.00

Principal Place of Business

11375 CORTEZ BLVD.
 SPRING HILL FL 34613

Mailing Address

8825 SKYMASTER DR.
 NEW PORT RICHEY FL 34654-5237
 US

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 **59-2908262**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
 Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

MOBLEY, KATHLEEN (M.D.)
8825 SKYMASTER DR.
NEW PORT RICHEY FL 34654

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

9. This corporation is eligible to satisfy its Intangible
 Tax filing requirement and elects to do so.
 (See criteria on back)



FILE NOW!!! FEE IS \$150.00
After MAY 1, 2000 Fee will be \$550.00
Make Check Payable to Department of State

10. Election Campaign Financing
 Trust Fund Contribution. ☐

\$5.00 May Be
 Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **V/P** ☐ Delete
 NAME **MCMULLEN, MARK M.D.**
 STREET ADDRESS **4086 GULF COAST DR**
 CITY-ST-ZIP **HERNANDO BCH FL 34607**

TITLE **V/T** ☒ Change ☐ Addition
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE **V/S** ☐ Delete
 NAME **MOBLEY, KATHLEEN (M.D.)**
 STREET ADDRESS **8825 SKYMASTER DR.**
 CITY-ST-ZIP **NEW PORT RICHEY FL**

TITLE **P/S** ☒ Change ☐ Addition
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

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

13. 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 or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

MARK 7. McMullen, MD
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

3609

CR2E034 (9/99)