

# 2003 NOT-FOR-PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**May 07, 2003 8:00 am**  
**Secretary of State**

05-07-2003 90177 013 \*\*\*\*70.00

**DOCUMENT # N00000000010**

1. Entity Name

**THE ASSOCIATION OF FLORIDA CHILDREN'S HOSPITALS, INC.**



Principal Place of Business

**807 CHILDREN'S WAY  
NEMOURS CHILDREN'S CLINIC  
JACKSONVILLE FL 32207**

Mailing Address

**807 CHILDREN'S WAY  
NEMOURS CHILDREN'S CLINIC  
JACKSONVILLE FL 32207**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country



☐ CHECK HERE IF MAKING CHANGES

4. FEI Number **59-3626378**

Applied For

Not Applicable

5. Certificate of Status Desired ☒

**\$8.75** Additional  
Fee Required

6. Name and Address of Current Registered Agent

**FREEMAN, LARRY J  
WOLFSON CHILDREN'S HOSPITAL  
800 PRUDENTIAL DRIVE  
JACKSONVILLE FL 32207**

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. I am familiar with, and accept the obligations of registered agent.

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 \$61.25**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

**\$5.00** May Be  
Added to Fees

**Make Check Payable to  
Florida Department of State**

10. OFFICERS AND DIRECTORS

|                |  |  |
|----------------|--|--|
| TITLE<br>NAME  | <b>PD<br/>WILKINSON, ALBERT H M.D.</b> | <input type="checkbox"/> Delete            |
| STREET ADDRESS | <b>807 CHILDREN'S WAY</b>              |  |
| CITY-ST-ZIP    | <b>JACKSONVILLE FL 32207</b>           |  |
| TITLE<br>NAME  | <b>VD<br/>HOWELL, R. RODNEY M.D.</b>   | <input checked="" type="checkbox"/> Delete |
| STREET ADDRESS | <b>1611 N.W. 12TH AVE</b>              |  |
| CITY-ST-ZIP    | <b>MIAMI FL 33136-1094</b>             |  |
| TITLE<br>NAME  | <b>STD<br/>AUBIN, MICHAEL D</b>        | <input type="checkbox"/> Delete            |
| STREET ADDRESS | <b>3001 W MARTIN LUTHER KING BLVD</b>  |  |
| CITY-ST-ZIP    | <b>TAMPA FL 33607-6387</b>             |  |
| TITLE<br>NAME  | <b>D<br/>ELLIS, MICHAEL</b>            | <input type="checkbox"/> Delete            |
| STREET ADDRESS | <b>9981 HEALTH PARK CIRCLE</b>         |  |
| CITY-ST-ZIP    | <b>FT MYERS FL 33908</b>               |  |
| TITLE<br>NAME  |  | <input type="checkbox"/> Delete            |
| STREET ADDRESS |  |  |
| CITY-ST-ZIP    |  |  |
| TITLE<br>NAME  |  | <input type="checkbox"/> Delete            |
| STREET ADDRESS |  |  |
| CITY-ST-ZIP    |  |  |

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

|                |  |   |
|----------------|--|---|
| TITLE<br>NAME  |  | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| STREET ADDRESS |  |   |
| CITY-ST-ZIP    |  |   |
| TITLE<br>NAME  |  | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| STREET ADDRESS |  |   |
| CITY-ST-ZIP    |  |   |
| TITLE<br>NAME  |  | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| STREET ADDRESS |  |   |
| CITY-ST-ZIP    |  |   |
| TITLE<br>NAME  |  | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| STREET ADDRESS |  |   |
| CITY-ST-ZIP    |  |   |
| TITLE<br>NAME  |  | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| STREET ADDRESS |  |   |
| CITY-ST-ZIP    |  |   |

12. 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 617, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

**Albert H. Wilkinson, Jr., M.D.**

SIGNATURE:

*Albert H. Wilkinson, Jr., M.D.*

2/20/03

904-202-8731

CR2E037 (10/02)