

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

**FILED**  
**Sep 02, 2003 8:00 am**  
**Secretary of State**

09-02-2003 90189 044 \*\*\*\*61.25

**DOCUMENT # N00000002766**

1. Entity Name

**NORTHEAST FLORIDA OPTOMETRIC SOCIETY, INC.**



Principal Place of Business

**2 ST. JOHN MEDICAL PARK DR., STE. 1  
ST. AUGUSTINE FL 32086**

Mailing Address

**2 ST. JOHN MEDICAL PARK DR., STE. 1  
ST. AUGUSTINE FL 32086**

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 **APPLIED FOR**

**020654116**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75** Additional  
Fee Required

☐ CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

**WILES, R. ANDREW  
2 ST. JOHN MEDICAL PARK DR., STE. 1  
ST. AUGUSTINE FL 32086**

7. Name and Address of New Registered Agent

Name **WILES, R. ANDREW**  
Street Address (P.O. Box Number is Not Acceptable)  
**2 ST. JOHN MEDICAL PARK DR. STE 1**  
City **ST AUGUSTINE** FL Zip Code **32086**

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

**R. Andrew Wiles**

**8/26/3**

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**

**After September 10, 2003, min will be \$236.25**

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 NAME STREET ADDRESS CITY-ST-ZIP	PD LENNON, JOHN 2504 CRILL AVE PALATKA FL 32177	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PED HORNING, JAMES O.D. 9930 MARGATE HILLS RD JACKSONVILLE FL 32256	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VD JOHNSON, LYNN OD 8626 BAYMEADOWS RD JACKSONVILLE FL 32256	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DS REED, JOANNE OD 11625 BRUSH RIDGE CIR S. JACKSONVILLE FL 32225	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T WILES, ANDREW OD 2 ST. JOHN MEDICAL PARK DR., STE. 1 ST. AUGUSTINE FL 32086	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

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
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

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.

SIGNATURE:

**R. Andrew Wiles OD**

**8/26/3 904-797-4628**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

CR2E037 (4/03)