

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # N01293

1. Entity Name

HEART OF FLORIDA HOSPITAL AUXILIARY, INC.

FILED
Mar 03, 2000 8:00 am
Secretary of State

03-03-2000 90231 035 ****61.25

Principal Place of Business Mailing Address
HEART OF FLORIDA REGIONAL MEDICAL CENTER HEART OF FLA. HOSPITAL
1615 US HWY 27 N POST OFFICE BOX 1187 ~~2935~~
DAVENPORT FL 33843 HAINES CITY FL 33845-1187 ~~DC 35~~
US 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 59-2373159 Applied For Not Applicable

5. Certificate of Status Desired ☐ \$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

WINEMAN, LORRAINE
1100 PENINSULA DR
HAINES CITY FL 33844

7. Name and Address of New Registered Agent

Name Shirley Good
Street Address (P.O. Box Number is Not Acceptable) 158 PALISADES DR
City DAVENPORT FL Zip Code 33837

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 Shirley A. Good DATE 2-17-2000
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW:
FEE IS \$61.25

9. Election Campaign Financing Trust Fund Contribution. ☐ \$5.00 May Be Added to Fees

Make Check Payable to
Department of State

10. OFFICERS AND DIRECTORS

TITLE	WINEMAN, LORRAINE	<input checked="" type="checkbox"/> Delete
NAME	1100 PENINSULA DR	
STREET ADDRESS	HAINES CITY FL 33844	
CITY-ST-ZIP		
TITLE	DOHERTY, WILLIAM	<input type="checkbox"/> Delete
NAME	103 BAYWOOD	
STREET ADDRESS	DUNDEE FL 33838	
CITY-ST-ZIP		
TITLE	PETROFF, URSULA	<input type="checkbox"/> Delete
NAME	12000 HWY 27N, #231	
STREET ADDRESS	DAVENPORT FL 33837	
CITY-ST-ZIP		
TITLE	GOOD, SHIRLEY	<input type="checkbox"/> Delete
NAME	158 PALISADES DR	
STREET ADDRESS	DAVENPORT FL 33837	
CITY-ST-ZIP		
TITLE	WRIGHT, DORIS	<input type="checkbox"/> Delete
NAME	118 ARROWHEAD LANE	
STREET ADDRESS	HAINES CITY FL 33844	
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE	VP HARRY A. McMullen	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	66 STEPHANOS DR	
STREET ADDRESS	HAINES CITY FL 33844	
CITY-ST-ZIP		
TITLE	PRES. WILLIAM DOHERTY	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	P.O. Box 1133	
STREET ADDRESS	DUNDEE FL 33838-1133	
CITY-ST-ZIP		
TITLE	P.E. URSULA PETROFF	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	12000 HWY 27N #231	
STREET ADDRESS	DAVENPORT FL 33837-0231	
CITY-ST-ZIP		
TITLE	T. Shirley Good	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	158 PALISADES DR.	
STREET ADDRESS	DAVENPORT FL 33837	
CITY-ST-ZIP		
TITLE	RS DORIS WRIGHT	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	118 ARROWHEAD LANE	
STREET ADDRESS	HAINES CITY, FL 33844	
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
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.

SIGNATURE: William Doherty DATE 2/17/2000 DAYTIME PHONE # 863 422-4971
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

CR2E037 (9/99)

#N01293

A0025216

Mail this postcard to people and businesses that send you mail

Please send mail to my new address beginning:

Month Day Year
2 2 00

My Name

OLD

Heart of Fla. Reg. Med. Center

Auxiliary, Inc.

P. O. Box 1107

Apt./Suite No.

City or Post Office

Haines City, FL 33845-1107

State

ZIP Code or ZIP+4

NEW Complete Street Address, PO Box, or Rural Route No. and Box No.

Apt./Suite No.

City or Post Office

Heart of Fla. Reg. Med. Center

Auxiliary, Inc.

P. O. Box 35

State

ZIP Code or ZIP+4

Account Number (If Applicable)

Haines City, FL 33845-0035

New Telephone No. (Optional)

Signature

Shirley A. Good Treas.

Today's Date

Month Day Year
2 1 2 2000

PS Form 3576, February 1995

Recipient: Be sure to record the above new address.