

2000 UNIFORM BUSINESS REPORT (UBR)

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

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

DOCUMENT # N01293

1. Entity Name
HEART OF FLORIDA HOSPITAL AUXILIARY, INC.

Principal Place of Business Mailing Address

HEART OF FLORIDA REGIONAL MEDICAL CENTER **HEART OF FLA. HOSPITAL**
1615 US HWY 27 N **POST OFFICE BOX ~~1487~~ ²⁹³⁵**
DAVENPORT FL 33843 **HAINES CITY FL 33845-~~1487~~ ^{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



DO NOT WRITE IN THIS SPACE

4. FEI Number Applied For

59-2373159 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~~ **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) 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 Department of State

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DD WINEMAN, LORRAINE 1100 PENINSULAR DR HAINES CITY FL 33844 <input checked="" type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	JRD HARRY A. McMullen 66 STEPHANOS DR HAINES CITY FL 33844 <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PK PD DOHERTY, WILLIAM 103 BAYWOOD DUNDEE FL 33838 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	PRES. WILLIAM DOHERTY P.O. BOX 1133 DUNDEE FL 33838-1133 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VED P.E PETROFF, URSULA 12000 HWY 27N, #231 DAVENPORT FL 33837 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	P.E. URSULA PETROFF 12000 HWY 27N #231 DAVENPORT FL 33837-0231 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T GOOD, SHIRLEY 158 PALISADES DR DAVENPORT FL 33837 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	T. Shirley Good 158 PALISADES DR. DAVENPORT FL 33837 <input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	RS WRIGHT, DORIS 118 ARROWHEAD LANE HAINES CITY FL 3844 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	RS DORIS WRIGHT 118 ARROWHEAD LANE HAINES CITY, FL 33844 <input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	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: *William Doherty* DATE: **2/17/2000** DAYTIME PHONE #: **863 422-4971**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR DATE Daytime Phone #

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
Haines City, FL 33845-1107

Apt./Suite No.

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.

State

ZIP Code or ZIP+4

Account Number (If Applicable)

P. O. Box 35
Haines City, FL 33845-0035

New Telephone No. (Optional)

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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.