

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

**FILED**  
**May 20, 2003 8:00 am**  
**Secretary of State**

04-22-2003 90069 014 \*\*\*\*61.25

**DOCUMENT # N08002**

1. Entity Name

**FLORIDA SOCIETY FOR ADOLESCENT PSYCHIATRY, INC.**



Principal Place of Business

**521 EAST PARK AVENUE  
TALLAHASSEE FL 32301**

Mailing Address

**521 EAST PARK AVENUE  
TALLAHASSEE FL 32301**

**55042362**

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 **NOT APPLICABLE**

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

Name

Street Address (P.O. Box Number is Not Acceptable)

City

**FL**

Zip Code

**ADAMS, MARGO S  
521 EAST PARK AVENUE  
TALLAHASSEE FL 32301**

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

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE **PED** ☐ Delete  
NAME **FARMER, SCOTT**  
STREET ADDRESS **815 E PRINCETON ST STE 3A**  
CITY-ST-ZIP **ORLANDO FL 32803**

TITLE **PD** ☒ Change ☐ Addition  
NAME **Farmer, Scott MD**  
STREET ADDRESS **615 E Princeton St, Suite 3A**  
CITY-ST-ZIP **Orlando, FL 32803**

TITLE **STD** ☐ Delete  
NAME **SOLLOWAY, MICHAEL**  
STREET ADDRESS **4190 BELFORT ROAD, SUITE 310**  
CITY-ST-ZIP **JACKSONVILLE FL 32218**

TITLE **PED** ☒ Change ☐ Addition  
NAME **Solloway, Michael MD**  
STREET ADDRESS **4190 Belfort Rd, Suite 310**  
CITY-ST-ZIP **Jacksonville, FL 32218**

TITLE **PD** ☒ Delete  
NAME **PRUITT, MICHAEL**  
STREET ADDRESS **8251 PHILLIPS HWY STE 4**  
CITY-ST-ZIP **JACKSONVILLE FL 32218**

TITLE **STD** ☐ Change ☒ Addition  
NAME **Gelfand Francine**  
STREET ADDRESS **1208 W. Dixie Ave.**  
CITY-ST-ZIP **Leesburg, FL 34748**

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

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

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

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

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Change ☐ 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:

**MARGO S. ADAMS 4/18/03 (850) 222-8404**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E037 (10/02)