

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 10, 2002 8:00 am
Secretary of State

02-10-2002 90014 023 *****61.25

0012880

DOCUMENT # N20559

1. Entity Name

CENTRAL FLORIDA SOCIETY OF OPHTHALMOLOGY, INC.

Principal Place of Business

Mailing Address

**16 W. COLUMBIA STREET
 ORLANDO FL 32806**

**16 W. COLUMBIA STREET
 ORLANDO FL 32806**

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

59-2862159

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

**HAAS, BRIAN M.D.
 16 W. COLUMBIA STREET
 ORLANDO FL 32806**

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.

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
 Department of State**

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE **PD** ☒ Delete
 NAME **HAAS, BRIAN D**
 STREET ADDRESS **16 W. COLUMBIA STREET**
 CITY-ST-ZIP **ORLANDO FL 32806**

TITLE **PD** ☒ Change ☐ Addition
 NAME **COHN, RICHARD A. M.D.**
 STREET ADDRESS **1850 GREENWICH AVE**
 CITY-ST-ZIP **WINTER PARK, FL 32792**

TITLE **VPD** ☒ Delete
 NAME **COHN, RICHARD A M.D.**
 STREET ADDRESS **41 W. KALEY STREET**
 CITY-ST-ZIP **ORLANDO FL 32806**

TITLE **VPD** ☒ Change ☐ Addition
 NAME **RUBIN, MARK S. MD**
 STREET ADDRESS **550 MEMORIAL CIRCLE #N**
 CITY-ST-ZIP **ORMOND BEACH, FL**

TITLE **SD** ☒ Delete
 NAME **RUBIN, MARK S M.D.**
 STREET ADDRESS **550 MEMORIAL CIRCLE #N**
 CITY-ST-ZIP **ORMOND BEACH FL**

TITLE **SD** ☒ Change ☐ Addition
 NAME **CHRISS, LISA M.D.**
 STREET ADDRESS **1925 MIZELL AVE. # 302**
 CITY-ST-ZIP **WINTER PARK, FL 32792**

TITLE **TD** ☒ Delete
 NAME **CHRISS, LISA M.D.**
 STREET ADDRESS **1925 MIZELL AVENUE #302**
 CITY-ST-ZIP **WINTER PARK FL 32792**

TITLE **TD** ☒ Change ☐ Addition
 NAME **POULOS, MARGARET, M.D.**
 STREET ADDRESS **115 W. COLUMBIA ST.**
 CITY-ST-ZIP **ORLANDO FL 32806**

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:

Margaret Poulos MD
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

01-22-02 407-843-2029
 Date Daytime Phone #

CP2E037 (9/01)