

SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER SEPTEMBER 15, 1999.
AMOUNT DUE ON OR BEFORE 09/15/99: \$61.25 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$236.25).

FILED
Aug 10, 1999 8:00 am
Secretary of State

08-10-1999 90011 050 ****61.25

**NONPROFIT
CORPORATION
ANNUAL REPORT
1999**



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # N45114

1. Corporation Name

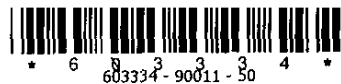
SOUTHEASTERN ASSOCIATION OF NEONATOLOGISTS, INC.

Principal Place of Business

4651 SHERIDAN ST
STE 400
HOLLYWOOD FL 33021
US

Mailing Address

4651 SHERIDAN ST.
STE 400
HOLLYWOOD FL 33021
US



2. Principal Place of Business

21 Suite, Apt. #, etc.

22 City & State

23 Zip Country

24 Zip Country

2a. Mailing Address

26 Suite, Apt. #, etc.

27 City & State

28 Zip Country

29 Zip Country

3. Date Incorporated or Qualified

09/12/1991

4. FEI Number

65-0283926

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution ☐

\$5.00 May Be
Added to Fees

9. Name and Address of Current Registered Agent

CHANDLER, BARRY D
4651 SHERIDAN ST SUITE 400
~~SUITE 400~~ SUITE 400
HOLLYWOOD FL 33021

10. Name and Address of New Registered Agent

81 Name

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

83 SUITE 400

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 617.0502 and 617.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 617.0503, Florida Statutes.

SIGNATURE

Signature typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

7/7/99

12. OFFICERS AND DIRECTORS

TITLE ☐ DELETE

NAME DAVID H. ADAMKIN MD
STREET ADDRESS UNIVERSITY OF LOUISVILLE
CITY-ST-ZIP LOUISVILLE KY

TITLE ☐ DELETE

NAME BLUBAUCH, ROBERT
STREET ADDRESS NCOMATAL SERVICES LTD
CITY-ST-ZIP MERIDIAN MS

TITLE ☐ DELETE

NAME CHANDLER, BARRY
STREET ADDRESS SHERIDAN HEALTHCORP
CITY-ST-ZIP HOLLYWOOD FL

TITLE ☐ DELETE

NAME YODER, CHARLES D. M
STREET ADDRESS MEMORIAL MISSION HOSPITAL
CITY-ST-ZIP ASHVILLE NC

TITLE ☐ DELETE

NAME SOLOMON, KEN
STREET ADDRESS 3030W. BUFFALO AVE.
CITY-ST-ZIP TAMPA FL

TITLE ☐ DELETE

NAME WELLS, DAVID H., M.D.
STREET ADDRESS 701 GROVE ROAD
CITY-ST-ZIP GREENVILLE SC

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE ☐ Change ☐ Addition

1.2 NAME

1.3 STREET ADDRESS

1.4 CITY-ST-ZIP

2.1 TITLE ☐ Change ☐ Addition

2.2 NAME

2.3 STREET ADDRESS

2.4 CITY-ST-ZIP

3.1 TITLE ☒ Change ☒ Addition

3.2 NAME

3.3 STREET ADDRESS

3.4 CITY-ST-ZIP

4.1 TITLE ☐ Change ☐ Addition

4.2 NAME

4.3 STREET ADDRESS

4.4 CITY-ST-ZIP

5.1 TITLE ☐ Change ☐ Addition

5.2 NAME

5.3 STREET ADDRESS

5.4 CITY-ST-ZIP

6.1 TITLE ☐ Change ☐ Addition

6.2 NAME

6.3 STREET ADDRESS

6.4 CITY-ST-ZIP

14. 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address with all other like empowered.

SIGNATURE:

SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7/7/99

954-986-7524

Date Daytime Phone #