

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

DOCUMENT # **N45114**

1. Entity Name

**SOUTHEASTERN ASSOCIATION OF NEONATOLOGISTS, INC.**



**FILED**  
**Jul 25, 2003 8:00 am**  
**Secretary of State**

07-25-2003 90088 022 \*\*\*\*61.25

0010045

Principal Place of Business  
**SHERIDAN CHILDREN'S HEALTHCARE SERVICES**  
**1613 N HARRISON PKWY. STE. 200**  
**SUNRISE FL 33323**  
**US**

Mailing Address  
**SHERIDAN CHILDREN'S HEALTHCARE SERVICES**  
**1613 N HARRISON PKWY. STE. 200**  
**SUNRISE FL 33323**  
**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 **65-0283926**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75** Additional  
Fee Required

☐ CHECK HERE IF MAKING CHANGES



6. Name and Address of Current Registered Agent

**CHANDLER, BARRY D.**  
**SHERIDAN CHILDREN'S HEALTHCARE SERVICES**  
**1613 N. HARRISON PKWY, STE 200**  
**SUNRISE FL 33323**

7. Name and Address of New Registered Agent

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. 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**  
**After September 10, 2003, min will be \$236.25**

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

TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>DAVID H. ADAMKIN MD</b>	
STREET ADDRESS	<b>UNIVERSITY OF LOUISVILLE</b>	
CITY-ST-ZIP	<b>LOUISVILLE KY</b>	
TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>BLUBAUGH, ROBERT</b>	
STREET ADDRESS	<b>NEONATAL SERVICES LTD</b>	
CITY-ST-ZIP	<b>MERIDIAN MS</b>	
TITLE	<b>P</b>	<input type="checkbox"/> Delete
NAME	<b>CHANDLER, BARRY</b>	
STREET ADDRESS	<b>1613 HARRISON PKWY, STE 200</b>	
CITY-ST-ZIP	<b>SUNRISE FL 33323</b>	
TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>YODER, CHARLES D. M</b>	
STREET ADDRESS	<b>MEMORIAL MISSION HOSPITAL</b>	
CITY-ST-ZIP	<b>ASHVILLE NC</b>	
TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>SOLOMON, KEN</b>	
STREET ADDRESS	<b>3030W. BUFFALO AVE.</b>	
CITY-ST-ZIP	<b>TAMPA FL</b>	
TITLE	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>WELLS, DAVID H., M.D.</b>	
STREET ADDRESS	<b>701 GROVE ROAD</b>	
CITY-ST-ZIP	<b>GREENVILLE SC</b>	

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
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:

**SIGNATURE REQUIRED - BARRY D. CHANDLER, M.D. - 7.18.03 - 828-2528**

Date

Daytime Phone #

CR2E037 (4/03)