

# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Mar 01, 2000 8:00 am**  
**Secretary of State**

03-01-2000 90050 045 \*\*\*\*61.25

**DOCUMENT # N94000000225**

1. Entity Name

**PASCO COUNTY IPA, INC.**

Principal Place of Business

Mailing Address

**37840 MEDICAL ARTS COURT  
 ZEPHYRHILLS FL 33541  
 US**

**37840 MEDICAL ARTS COURT  
 ZEPHYRHILLS FL 33541-4325  
 US**

2. Principal Place of Business

**2323 Curlew Road**

3. Mailing Address

**2323 Curlew Road**

Suite, Apt. #, etc.

**Suite 7E**

Suite, Apt. #, etc.

**Suite 7E**

City & State

**Palm Harbor, FL**

City & State

**Palm Harbor, FL**

4. FEI Number

**59-3218197**

Applied For

Not Applicable

Zip

**34683**

Country

**US**

Zip

**34683**

Country

**US**

5. Certificate of Status Desired ☐

**\$8.75 Additional  
 Fee Required**

6. Name and Address of Current Registered Agent

**CORPORATION INFORMATION SERVICES INC.  
 1201 HAYS STREET  
 TALLAHASSEE FL 32301**

7. Name and Address of New Registered Agent

Name

**Charles Jacobson**

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

**c/o Jacobson Consulting, Inc.**

**2323 Curlew Road, Suite 7E**

City

**Palm Harbor**

**FL**

Zip Code  
**34683**

DO NOT WRITE IN THIS SPACE



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

*Charles Jacobson*

**Charles Jacobson, Mgmt Co.**

**2/10/00**

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

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>T GROSSBARD, LEE J. M.D. 37840 MEDICAL ARTS CT. ZEPHYRHILLS FL</b>	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>PD BEDI, BEN M.D. % 37840 MEDICAL ARTS COURT ZAPHYRHILLS FL</b>	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>DVP BLACKSTONE, HARRY M.D. % 37840 MEDICAL ARTS COURT ZAPHYRHILLS FL</b>	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>SD CASELNOVA, MICHAEL M.D. % 37840 MEDICAL ARTS COURT ZAPHYRHILLS FL</b>	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>D</b>	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>PD PAUL F. MARCH, M.D. 38034 Medical Center Avenue Zephyrhills, FL 33540</b>	<input checked="" type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>V'S-D HARVEY FELD, M.D. 7050 Gall Blvd. Zephyrhills, FL 33541</b>	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>T D NESTOR M. GUERRERO-ARIAS, M.D. 37740 Meridian Avenue Dade City, FL 33525</b>	<input checked="" type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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:

*Paul F. March*  
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**Paul F. March, M.D., President 2/11/00 813-788-5531**

Date

Daytime Phone #

CR2E037 (9/99)