

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 07, 2001 8:00 am
Secretary of State

03-07-2001 90608 016 ****61.25

C-17

DOCUMENT # N94000003008

1. Entity Name

LIFELINK TRANSPLANTATION INSTITUTE, INC.

Principal Place of Business

Mailing Address

409 BAYSHORE BLVD
 TAMPA FL 33606

409 BAYSHORE BLVD
 TAMPA FL 33606

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

59-3253621

Applied For

Not Applicable

5. Certificate of Status Desired

\$8.75 Additional Fee Required



DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

CAMBELL, JOHN R
409 BAYSHORE BLVD
TAMPA FL 33606

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 NAME STREET ADDRESS CITY-ST-ZIP	CEOD SHIRES, DANA L JR MD 409 BAYSHORE BLVD TAMPA FL 33606	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD HEINRICHS, DENNIS F B.A. 409 BAYSHORE BLVD TAMPA FL 33606	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D KAHANA, LAWRENCE M.D. 409 BAYSHORE BLVD TAMPA FL 33606	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T STOCKMAN, JOHN E 601 BAYSHORE BLVD. STE. 600 TAMPA FL 33606	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D LEFOR, WILLIAM M CLD 409 BAYSHORE BLVD TAMPA FL 33606	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D PFAFF, WILLIAM W MD UF, SHANDS TEACHING HOSPITAL J-286 GAINESVILLE FL 32611	<input type="checkbox"/> Delete

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
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
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 an other like empowered.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

John R. Cambell
JOHN R. CAMPELL

3/26/01
3/26/01

(813) 258-6515
(813) 258-6515

CR2E037 (10/00)