

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Sep 04, 2002 8:00 am
Secretary of State

09-04-2002 90088 049 ****61.25

DOCUMENT # N94000003008

1. Entity Name

LIFELINK TRANSPLANTATION INSTITUTE, INC.

Principal Place of Business

409 BAYSHORE BLVD
 TAMPA FL 33606

Mailing Address

409 BAYSHORE BLVD
 TAMPA FL 33606

2. Principal Place of Business

Suite, Apt. #, etc.

City & State

Zip

Country

3. Mailing Address

Suite, Apt. #, etc.

City & State

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

correct spelling → **CAMPBELL**
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. 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

After September 13, 2002,
 min. will be **\$236.25.**

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 HEINRICH, 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	S John R. Campbell 409 Bayshore Blvd. Tampa FL 33606	<input 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
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: *William W Pfaff*

8/30/02 813-253-2640

CR2E037 (4/02)

