

2000 UNIFORM BUSINESS REPORT (UBR)

FILED
Aug 11, 2000 8:00 am
Secretary of State

08-11-2000 90093 013 ****61.25

DOCUMENT # N95000004871
 1. Entity Name
NORTH FLORIDA PHYSICIANS ASSOCIATION, INC.

Principal Place of Business Mailing Address
 720 GILMORE STREET 720 GILMORE STREET
 SUITE 600 SUITE 600
 JACKSONVILLE FL 32204 JACKSONVILLE FL 32204

2. Principal Place of Business 3. Mailing Address
710 LOMAX ST
 Suite, Apt. #, etc. Suite, Apt. #, etc.
Jacksonville

City & State City & State
FL
 Zip Country Zip Country
32204 **USA**



DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent
RAX CO.
50 NORTH LAURA STREET
SUITE 3300
JACKSONVILLE FL 32202

4. FEI Number Applied For
59-3343188 Not Applicable
 5. Certificate of Status Desired **\$8.75 Additional Fee Required**

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.
 SIGNATURE: *[Signature]* **JAMES N. BURT** **8/10/00**
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
After September 13, 2000, 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

| | | |
|----------------|-----------------------|--|
| TITLE | D | <input type="checkbox"/> Delete |
| NAME | ALLEN, JULIAN E M.D. | |
| STREET ADDRESS | 720 GILMORE STREET | |
| CITY-ST-ZIP | JACKSONVILLE FL 32204 | |
| TITLE | PD | <input type="checkbox"/> Delete |
| NAME | BURT, JAMES N M.D. | |
| STREET ADDRESS | 720 GILMORE STREET | |
| CITY-ST-ZIP | JACKSONVILLE FL 32204 | |
| TITLE | D | <input checked="" type="checkbox"/> Delete |
| NAME | CALHOUN, PATRICIA | |
| STREET ADDRESS | 720 GILMORE STREET | |
| CITY-ST-ZIP | JACKSONVILLE FL 32204 | |
| TITLE | D | <input checked="" type="checkbox"/> Delete |
| NAME | JACOBS, MICHAEL | |
| STREET ADDRESS | 720 GILMORE STREET | |
| CITY-ST-ZIP | JACKSONVILLE FL 32204 | |
| TITLE | D | <input type="checkbox"/> Delete |
| NAME | HARKNESS, CHARLES D | |
| STREET ADDRESS | 720 GILMORE STREET | |
| CITY-ST-ZIP | JACKSONVILLE FL 32204 | |
| TITLE | D | <input checked="" type="checkbox"/> Delete |
| NAME | KOPPEL, CHRIS | |
| STREET ADDRESS | 720 GILMORE STREET | |
| CITY-ST-ZIP | JACKSONVILLE FL 32204 | |

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 |
| 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]* **JAMES N. BURT, MD** **8/10/00** **909 355-6583**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E037 (5/00)