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**NONPROFIT
CORPORATION
ANNUAL REPORT
1999**



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # N96000001871

1. Corporation Name

BAY AREA SOCIETY OF ANESTHESIOLOGISTS, INC.

Principal Place of Business

Mailing Address

TAMPA GENERAL HOSPITAL. DEPT. OF ANESTH.
ROOM G-208. DAVIS ISLANDS
TAMPA FL 33606

TAMPA GENERAL HOSPITAL. DEPT. OF ANESTH.
ROOM G-208. DAVIS ISLANDS
TAMPA FL 33606



2. Principal Place of Business

2a. Mailing Address

3. Date Incorporated or Qualified

21

26

04/02/1996

Suite, Apt. #, etc.

Suite, Apt. #, etc.

4. FEI Number

Applied For

59-3391327

Not Applicable

22

27

City & State

City & State

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

23

28

Zip

Country

Zip

Country

6. Election Campaign Financing
Trust Fund Contribution ☐

\$5.00 May Be
Added to Fees

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

BARRETT, CHARLES V III
701 N. FRANKLIN ST.
SUITE 300
TAMPA FL 33602

81 Name

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

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 617.0502 and 617.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 617.0503, Florida Statutes.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

TITLE **D** ☐ DELETE
NAME **DOWNS, JOHN B M.D.**
STREET ADDRESS **T.G.H., DEPT. OF ANESTH., ROOM G-208**
CITY-ST-ZIP **TAMPA FL 33606**

1.1 TITLE **P Robert Bedford, MD** ☐ Change ☒ Addition
1.2 NAME **James A Haley VA Hosp Anes. (123)**
1.3 STREET ADDRESS **13000 Bruce B Downs Blvd.**
1.4 CITY-ST-ZIP **Tampa, FL 33612**

TITLE **D** ☐ DELETE
NAME **SMITH, PATRICIA**
STREET ADDRESS **T.G.H., DEPT. OF ANESTH., ROOM G-208**
CITY-ST-ZIP **TAMPA FL 33606**

2.1 TITLE **VP Karen Slack, MD** ☐ Change ☒ Addition
2.2 NAME **90 Bahama Circle**
2.3 STREET ADDRESS **Tampa, FL 33606**
2.4 CITY-ST-ZIP

TITLE **P** ☒ DELETE
NAME **WARREN, JOHN M**
STREET ADDRESS **3704 SWANN AVE**
CITY-ST-ZIP **TAMPA FL 33609**

3.1 TITLE ☐ Change ☐ Addition
3.2 NAME
3.3 STREET ADDRESS
3.4 CITY-ST-ZIP

TITLE **VP** ☒ DELETE
NAME **MIGUEL, RAFAEL M**
STREET ADDRESS **USF ANETHES MDC 59, 12901 BRUCE B DOWNS BL**
CITY-ST-ZIP **TAMPA FL 33612**

4.1 TITLE ☐ Change ☐ Addition
4.2 NAME
4.3 STREET ADDRESS
4.4 CITY-ST-ZIP

TITLE **DST** ☐ DELETE
NAME **SAVIELLO, GEORGE M**
STREET ADDRESS **USF ANTHES MDC 59, 12901 BRUCE B DOWNS BLV**
CITY-ST-ZIP **TAMPA FL 33612**

5.1 TITLE ☐ Change ☐ Addition
5.2 NAME
5.3 STREET ADDRESS
5.4 CITY-ST-ZIP

TITLE ☐ DELETE
NAME
STREET ADDRESS
CITY-ST-ZIP

6.1 TITLE ☐ Change ☐ Addition
6.2 NAME
6.3 STREET ADDRESS
6.4 CITY-ST-ZIP

14. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(l), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

Signature Required
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

2-4-99 (813) 251-7082
Date Daytime Phone #

CR2E037 (1/198)