

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # N96000001871

1. Entity Name

BAY AREA SOCIETY OF ANESTHESIOLOGISTS, INC.

FILED
Mar 13, 2000 8:00 am
Secretary of State

03-13-2000 90032 010 ****61.25

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

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number

59-3391327

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

BARRETT, CHARLES V III
307 SOUTH FIELDING AVENUE
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	D	<input type="checkbox"/> Delete
NAME	DOWNES, JOHN B M.D.	
STREET ADDRESS	T.G.H., DEPT. OF ANESTH., ROOM G-208	
CITY-ST-ZIP	TAMPA FL 33606	

TITLE	P	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	Malcolm Klein, MD	
STREET ADDRESS	94 Baltic Circle	
CITY-ST-ZIP	Tampa, FL 33606	

TITLE	D	<input type="checkbox"/> Delete
NAME	SMITH, PATRICIA	
STREET ADDRESS	T.G.H., DEPT. OF ANESTH., ROOM G-208	
CITY-ST-ZIP	TAMPA FL 33606	

TITLE	VP	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	Eugene Fu, MD	
STREET ADDRESS	Anesthesiology, USF - MDC 59	
CITY-ST-ZIP	12901 Bruce B Downs, Tampa, 33612	

TITLE	P	<input checked="" type="checkbox"/> Delete
NAME	BEDFORD, ROBERT MD	
STREET ADDRESS	13000 BRUCE B DOWNS BLVD	
CITY-ST-ZIP	TAMPA FL 33612	

TITLE	DST	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	Hans Schweiger, MD	
STREET ADDRESS	Anesthesiology, USF, MDC 59	
CITY-ST-ZIP	12901 Bruce B Downs Blvd, Tampa 33612	

TITLE	VP	<input checked="" type="checkbox"/> Delete
NAME	SLACK, KAREN MD	
STREET ADDRESS	90 BAHAMA CIRCLE	
CITY-ST-ZIP	TAMPA FL 33606	

TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

TITLE	DST	<input checked="" type="checkbox"/> Delete
NAME	SAVIELLO, GEORGE M	
STREET ADDRESS	USF ANTHES MDC 59, 12901 BRUCE B DOWNS BLV	
CITY-ST-ZIP	TAMPA FL 33612	

TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

TITLE		<input type="checkbox"/> Delete
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:

John B. Downes, MD
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

3/8/00

813-251-7082

Date

Daytime Phone #

CR2E037 (9/99)