

SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER SEPTEMBER 15, 1999.  
AMOUNT DUE ON OR BEFORE 09/15/99: \$61.25 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$236.25).

NONPROFIT  
CORPORATION  
ANNUAL REPORT  
1999



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

FILED  
Jul 28, 1999 8:00 am  
Secretary of State

07-28-1999 90003 031 \*\*\*\*61.25

DOCUMENT # N98000005616

1. Corporation Name

LUTHERN HEALTH MINISTRIES OF NORTH CENTRAL FLORIDA, INC.

Principal Place of Business

3968 N.W. 25TH CIRCLE  
GAINESVILLE FL 32606

Mailing Address

3968 N.W. 25TH CIRCLE  
GAINESVILLE FL 32606



2. Principal Place of Business

21 Suite, Apt. #, etc.

23 City & State

24 Zip

Country

2a. Mailing Address

26 Suite, Apt. #, etc.

27 City & State

28 Zip

Country

3. Date Incorporated or Qualified

09/30/1998

4. FEI Number

Applied For  
☒ Not Applicable

5. Certificate of Status Desired

\$8.75 Additional  
Fee Required

6. Election Campaign Financing  
Trust Fund Contribution

\$5.00 May Be  
Added to Fees

9. Name and Address of Current Registered Agent

LAPEER, RUSSELL W  
445 N.E. 8TH AVE  
OCALA FL 34470

10. Name and Address of New Registered Agent

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

TITLE D  
NAME CADE, ROBERT M.D.  
STREET ADDRESS DEPT. OF MEDICINE, UNIV. OF FL HEALTH SCIEN  
CITY-ST-ZIP GAINESVILLE FL 32601

TITLE D  
NAME DEAN, SANDRA R.N.  
STREET ADDRESS DEPT. OF NURSING, N. FL REGIONAL MEDICAL CN  
CITY-ST-ZIP GAINESVILLE FL 32606

TITLE D  
NAME PETIT, PAUL M.D.  
STREET ADDRESS 6436 BORG STREET  
CITY-ST-ZIP LEESBURG FL 34748-7713

TITLE DT  
NAME REICH, CHARLES REV.  
STREET ADDRESS 9700 W. NEWBERRY CENTER, NEWBERRY RD.  
CITY-ST-ZIP GAINESVILLE FL 32606

TITLE DS  
NAME SILBERMAN, DONALD  
STREET ADDRESS 4809 NW 36TH PLACE  
CITY-ST-ZIP GAINESVILLE FL 32606

TITLE DP  
NAME WIECHMANN, GERALD PH.D  
STREET ADDRESS 3968 NW 25TH CIRCLE  
CITY-ST-ZIP GAINESVILLE FL 32606

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE ☐ Change ☐ Addition

1.2 NAME

1.3 STREET ADDRESS

1.4 CITY-ST-ZIP

2.1 TITLE ☐ Change ☐ Addition

2.2 NAME

2.3 STREET ADDRESS

2.4 CITY-ST-ZIP

3.1 TITLE ☐ Change ☐ Addition

3.2 NAME

3.3 STREET ADDRESS

3.4 CITY-ST-ZIP

4.1 TITLE ☐ Change ☐ Addition

4.2 NAME

4.3 STREET ADDRESS

4.4 CITY-ST-ZIP

5.1 TITLE ☐ Change ☐ Addition

5.2 NAME

5.3 STREET ADDRESS

5.4 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)(i), 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

7/18/99

352-373-2316

CR2E037 (5/99)