


**2003 FOR PROFIT CORPORATION  
AMENDED UNIFORM BUSINESS REPORT (UBR)**

FILED

03 NOV -6 AM 9:49

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

<b>DOCUMENT # P00000058032</b>			
1. Entity Name <b>BEACON HEALTH, P.A.</b>			
Principal Place of Business 3501 HEALTH CENTER BLVD. STE 2220 BONITA SPRINGS, FL 34135		Mailing Address 3501 HEALTH CENTER BLVD. STE 2220 BONITA SPRINGS, FL 34135	
2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country



☐ CHECK HERE IF MAKING CHANGES

4. FEI Number <b>65-1017461</b>		Applied For <input type="checkbox"/> Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent <b>MCCORMACK, DEBRA J M.D. 20781 GROVELINE CT. ESTERO, FL 33928</b>		7. Name and Address of New Registered Agent Name <b>McCormack, Debra J., M.D.</b> Street Address (P.O. Box Number is Not Acceptable) <b>3501 Health Center Blvd., Suite 2220</b> City <b>Bonita Springs</b> FL Zip Code <b>34135</b>	
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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 *Debra J. McCormack* **Debra J. McCormack** 10/28/2003  
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when resigning) DATE

<p>FILE NOW!! FEE IS \$150.00 After May 1, 2003 Fee will be \$550.00 Amended UBR is \$85.25 Make Check Payable to Florida Department of State</p>	<p>9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees</p>
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D MCCORMACK, DEBRA J M.D. 20781 GROVELINE CT. ESTERO, FL 33928 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	D, P, S, T McCormack, Debra J., M.D. 3501 Health Center Blvd., Suite 2220 Bonita Springs, FL 34135 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D PERKO, CYNTHIA M.D. 665 MAINSAIL PL. NAPLES, FL 34110 <input checked="" type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>600024477246</b> <b>11/06/03--01027--002 **61.25</b>
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	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"/> Delete	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"/> Delete	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"/> Delete	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 607, 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: *Debra J. McCormack M.D. Director*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR **Debra J. McCormack, Director** Daytime Phone #

CR2E034 (10/02)