

# 2002 UNIFORM BUSINESS REPORT (UBR)

0112794 AV

**DOCUMENT # P0000077134**

1. Entity Name  
**THE HEALTH CENTER OF ORLANDO, INC.**

APPROVED  
AND  
FILED

02 MAR 15 PM 12:58

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

Principal Place of Business  
4875 CASON COVE DR  
ORLANDO FL 32811

Mailing Address  
P.O. BOX 618246  
ORLANDO FL 32861-8246



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number  
**59-3664423**

Applied For  
Not Applicable

Zip Country

Zip Country

5. Certificate of Status Desired  **\$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**CORPORATION SERVICE COMPANY  
1201 HAYS STREET  
TALLAHASSEE, FL 32301**

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 \_\_\_\_\_ DATE \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so.

**FILE NOW!!! FEE IS \$150.00  
After May 1, 2002 Fee will be \$550.00  
Make Check Payable to Department of State**

10. Election Campaign Financing Trust Fund Contribution.  **\$5.00** May Be Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>D</b> <b>STRAWN, STEVE</b> 4875 CASON COVE DR ORLANDO FL 32861	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>PT</b> <b>RYKIEL, STEPHEN</b> 4875 CASON COVE DR ORLANDO FL 32811	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>S</b> <b>RODRIGUEZ, NANCY</b> 4875 CASON COVE DR ORLANDO FL 32811	<input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>D</b> <b>Strawn, Steve</b> 3547 Betty Ford Road Murfreesboro, TN 37130	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>500005133675--3</b> <b>-03/19/02--01027--010</b> <b>****150.00 ****150.00</b>	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>S</b> <b>Retenio, Angela</b> 4875 Cason Cove Dr Orlando, FL 32811	<input checked="" type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
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"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

13. 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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: Stephen Rykiel **REQUIRE** 2/20/02 407-420-2090  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/01)



ACCOUNT NO. : 072100000032

REFERENCE : 462283 7304648

AUTHORIZATION :

COST LIMIT : \$ PPD

ORDER DATE : March 12, 2002

ORDER TIME : 11:37 AM

ORDER NO. : 462283-080

CUSTOMER NO: 7304648

CUSTOMER: Ms. Jacquelyn O. Ayers  
Health Centers  
421 W. College Street

Murfreesboro, TN 37130

ANNUAL REPORT FILING

NAME: THE HEALTH CENTER OF ORLANDO

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

- CERTIFIED COPY
- XX            PLAIN STAMPED COPY
- CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Susie Knight-EXT#1156

EXAMINER'S INITIALS: \_\_\_\_\_

RECEIVED  
02 MAR 15 PM 12:56  
DEPARTMENT OF STATE  
DIVISION OF CORPORATIONS  
TALLAHASSEE, FLORIDA