

2002 UNIFORM BUSINESS REPORT (UBR)

APPROVED
AND
FILED

0128110 AV

DOCUMENT # P0000077141

1. Entity Name
THE HEALTH CENTER OF MERRITT ISLAND, INC.

02 MAR 15 PM 1:05

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business
500 CROCKETT BLVD
MERRITT ISLAND FL 32954

Mailing Address
P.O. BOX 540760
MERRITT ISLAND FL 32954



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
59-3664424

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. Boxes from business use are acceptable)
City State Zip Code
FL

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.
(See criteria on back)

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	D STRAWN, STEVE 500 CROCKETT BLVD MERRITT ISLAND FL 32954	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PT WILLIAMS, LESLIE F 500 CROCKETT BLVD MERRITT ISLAND FL 32953	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S FINK, ALAINE 500 CROCKETT BLVD MERRITT ISLAND FL 32953	<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		<input type="checkbox"/> Delete

TITLE NAME STREET ADDRESS CITY-ST-ZIP	D Steve Strawn 3547 Betty Ford Rd. Murfreesboro, TN 37130	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	200005133752-3 -03/19/02--01027--012 ****150.00 ****150.00	<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
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 another like empowered.

SIGNATURE: Leslie F Williams 2-25-02 321-454-4035
Date Daytime Phone #

CR2E034 (9/01)



ACCOUNT NO. : 072100000032
 REFERENCE : 462283 7304648
 AUTHORIZATION :
 COST LIMIT : \$ PPD

ORDER DATE : March 12, 2002
 ORDER TIME : 11:36 AM
 ORDER NO. : 462283-070
 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 MERRITT ISLAND

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

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: _____