2002 UNIFORM BUSINESS REPORT (UBR)

SIGNATURE:

DOCUMENT # P0000077165 1. Entity Name THE HEALTH CENTER OF PENSACOLA, INC.						FILED 02 MAR 15 PM 12: 30			
Principal Plac 8475 UNIVERS PENSACOLA I		Mailing Address 8475 UNIVERSITY PKWY PENSACOLA FL 32514				SECRETARY OF STATE TALLAHASSEE, FLORIDA			
Principal Place of Business Address Address									
Suite, Apt. #, etc.		Suite, Apt. #, etc.				DO NOT WRITE IN T	HIS SPACE		
City & State		City & State			4 5	A FFI Allert and For			
						59-3664432		Not Applicable	
Zip	Zip Country Zip		Country		5. (Certificate of Status Desired	\$8.75 / Fee Requ		
6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent Name					
CORPORATION SERVICE COMPANY 1201 HAYS STREET TALLAHASSEE, FL 32301					Address (P.O. Box Number is Not Acceptable)				
				City	FL Zip Code				
SIGNATURE Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required part of the first policies) 9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable. (NOTE: Registered Agent signature required agent and title if applicable.)					00 50.00	10. Election Campaign Financin Trust Fund Contribution.		5.00 May Be ded to Fees	
11.	OFFICERS AND D		12.		AD	DITIONS/CHANGES TO OFFICERS			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D Strawn, Steve 8475 University PKWY Pensacola FL 32514	Delete	TITLE NAME STREET A CITY-ST	ADDRESS	3547	Strawn Bettyford Road reeslooro, TN 3	√ Perang 1 713∂	ge Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P BALLAY, JOSEPH 915 ARIOLA DRIVE PENSACOLA BEACH FL 32561		TITLE NAME STREET A CITY-ST	ADDRESS ZIP		Change Addition 50005133785-0 -03/19/02-01027-019 ****150.00 ****150.00			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S SHEETS, LINDA 1365 TOBIAS ROAD CANTONMENT FL 32533	☐ Delete	TITLE NAME STREET A	address -Zip			Chang	ge Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET / CITY-ST	- 1			☐ Chang	ge	
TITLE NAME STREET ADDRESS CITY-ST-ZIP		□ Delete	TITLE NAME STREET A CITY-ST	ADDRESS - ZIP			☐ Chang	e Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	:	□ Delete	TITLE NAME STREET / CITY-ST				☐ Chang	e Addition	
indicated of the cor	certify that the information supplied with the on this report or supplemental report is treporation or the receiver or trustee empower or on an attachment with a docess, with the content of the content	rue and accurate and that my rered to execute this report as	r signaturi	e shall ha	ave the same i	legal effect as if made under oath; t	nat I am an offic	cer or director	



ACCOUNT NO. : 072100000032

REFERENCE: 462283 7304648

AUTHORIZATION :

COST LIMIT : \$ PPD

ORDER DATE: March 12, 2002

ORDER TIME : 11:43 AM

ORDER NO. : 462283-095

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 PENSACOLA

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:

DEPARIMENT OF STATE