

2002 UNIFORM BUSINESS REPORT (UBR)

APPROVED
AND
FILED

0011079 AV

02 MAR 15 PM 12:33

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



DO NOT WRITE IN THIS SPACE

DOCUMENT # P0000077171

1. Entity Name
THE HEALTH CENTER OF DAYTONA BEACH, INC.

Principal Place of Business 550 NATIONAL HEALTHCARE DR DAYTONA BEACH FL 32114	Mailing Address 550 NATIONAL HEALTHCARE DR DAYTONA BEACH FL 32114
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2. Principal Place of Business Suite, Apt. #, etc.	3. Mailing Address Suite, Apt. #, etc.
City & State	City & State

Zip	Country	Zip	Country
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4. FEI Number 59-3664429	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

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

7. Name and Address of New Registered Agent

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.
(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	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PT BAIRD, ROSS 550 NATL HEALTHCARE DR DAYTONA BEACH FL 32114 <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S STINSON, ELIZABETH BETSY 550 NATL HEALTHCARE DR DAYTONA BEACH FL 32114 <input checked="" type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D STRAWN, STEVE 550 NATL HEALTHCARE DR DAYTONA BEACH FL 32114 <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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition 100005133791-2 -03/19/02--01027--021 ****150.00 ****150.00
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition D Steve Strawn 3547 Betty Ford Road Murfreesboro, TN 37130
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: **2/19/02** **(386) 257-6362**
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 : 11:41 AM
 ORDER NO. : 462283-085
 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 DAYTONA
 BEACH

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