

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

FILED
Mar 05, 2003 8:00 am
Secretary of State

03-05-2003 90024 006 ***150.00

DOCUMENT # P01000033347

1. Entity Name
CARE NEUROLOGY, P.A.



Principal Place of Business
**1219 EAST AVE SOUTH SUITE 202
SARASOTA FL 34239**

Mailing Address
**1219 EAST AVE SOUTH SUITE 202
SARASOTA FL 34239**



2. Principal Place of Business
1219 East Ave. South

3. Mailing Address

Suite, Apt. #, etc.

Suite 202

City & State

Sarasota, FL

City & State

Zip
34239

Country

Zip

Country

☐ CHECK HERE IF MAKING CHANGES

4. FEI Number **65-1098323**

Applied For

Not Applicable

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

6. Name and Address of Current Registered Agent

**FRANCZEK, SCOTT P M.D.
1016 CALOOSA DR.
SARASOTA FL 34234**

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State**

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

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **D** ☐ Delete
NAME **FRANCZEK, SCOTT P M.D.**
STREET ADDRESS **1016 CALOOSA DR.**
CITY-ST-ZIP **SARASOTA FL 34234**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ Delete
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STREET ADDRESS
CITY-ST-ZIP

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CITY-ST-ZIP

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:

SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/13/03

941-953-5252

Date

Daytime Phone #

CR2E034 (10/02)