2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 25, 2003 8:00 am
Secretary of State
04-25-2003 90278 035 ***150.00

DOCUMENT # P01000107593

1. Entity Name
SCHLAFMAN ANESTHESIA, INC.

Principal Place of Business	Mailing Address
12659 NEW BRITTANY BOULEVARD BUILDING 12 FORT MYERS FL 33907	12659 NEW BRITTANY BOULEVARD BUILDING 12 FORT MYERS FL 33907

☑ CHECK HERE IF MAKING CHANGES

2. Principal Place of Business		3. Mailing Address	
6900-29 Daniels PKWY		6900-29 Daniels PKWY	
Suite, Apt. #, etc.: #199		Suite, Apt. #, etc.: #199	
City & State: FT. MYERS, FL		City & State: FT. MYERS, FL	
Zip: 33912	Country: USA	Zip: 33912	Country: USA

4. FEI Number 65-1158544 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent

MAYLE, LOVELL L MD
15741 QUEENSFERRY DRIVE
FORT MYERS FL 33912

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 NAME STREET ADDRESS CITY-ST-ZIP	PRES MAYLE, LOVELL L MD 15741 QUEENSFERRY DR FORT MYERS FL 33912	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
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CR2E034 (10/02)

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: Lovell L Mayle, MD 4-18-03 239561462
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #