

2001 UNIFORM BUSINESS REPORT (UBR)

FILED

Feb 05, 2001 8:00 am
Secretary of State

02-05-2001 90123 044 ***150.00

DOCUMENT # P93000045882

1. Entity Name
MCLEOD ORTHOPEDIC CLINIC, P.A.

Principal Place of Business
**504 PALMETTO ST.
NEW SMYRNA BEACH FL 32168**

Mailing Address
**504 PALMETTO ST.
NEW SMYRNA BEACH FL 32168**

2. Principal Place of Business
504 Palmetto St, NSB FL 32168
Suite, Apt. #, etc.

3. Mailing Address
504 Palmetto St 32168 NSB FL
Suite, Apt. #, etc.



DO NOT WRITE IN THIS SPACE

City & State
NSB FL
Zip
32168 Country

City & State
NSB FL
Zip
32168 Country
USA

4. FEI Number **59-3188715**
Applied For
☐ Not Applicable

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

6. Name and Address of Current Registered Agent
**MCLEOD, WILLIAM P M.D.
504 PALMETTO ST.
NEW SMYRNA BEACH FL 32168**

7. Name and Address of New Registered Agent
Name **William P. McLeod MD**
Street Address (P.O. Box Number is Not Acceptable)
504 palmetto St
City **New Smyrna Beach FL** Zip Code **32168**

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 **[Signature]** **William P. McLeod MD principal** **1-9-01**
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

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, 2001 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	D <input type="checkbox"/> Delete MCLEOD, WILLIAM P M.D. 504 PALMETTO ST. NEW SMYRNA BEACH FL 32168
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
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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
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
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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 **[Signature]** **William P. McLeod MD** **1-9-01** **904 421 9601**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/00)