

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

DOCUMENT # **P93000075810**



1. Entity Name
C. R. ANESTHESIA, P.A.

Principal Place of Business
**6201 N SUNCOAST BLVD
SEVEN RIVERS COMMUNITY HOSP DEPT ANEST
CRYSTAL RIVER FL 32629**

Mailing Address
**PO BOX 457
CRYSTAL RIVER FL 34423-0451**

**FILED
Feb 04, 2003 8:00 am
Secretary of State**

02-04-2003 90138 022 ***150.00



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number	59-3208344	Applied For
		Not Applicable

Zip

Country

Zip

Country

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

6. Name and Address of Current Registered Agent

**BERGER, ROBERT M MD
6201 N SUNCOAST BLVD
SEVEN RIVERS COMMUNITY HOSPITAL DEPT ANEST
CRYSTAL RIVER FL 32629**

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	DP BERGER, ROBERT M MD 6201 N SUNCOAST BLVD CRYSTAL RIVER FL 32629	<input checked="" type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DST CALODNEY, LEONARD MD 6201 N SUNCOAST BLVD CRYSTAL RIVER FL 32629	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D SLEIGHT, EDWARD MD 6201 N SUNCOAST BLVD CRYSTL RIVER FL	<input checked="" type="checkbox"/> Delete	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"/> Delete	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"/> Delete	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"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(l), 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

1/27/03 352-795-8394

Date

Daytime Phone #

CR2E034 (10/02)