

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 14, 2002 8:00 am
Secretary of State

03-14-2002 90060 001 ***150.00

DOCUMENT # P93000078415
 1. Entity Name
NORTH FLORIDA EYE INSTITUTE, P.A.

Principal Place of Business 3009 4TH ST MARIANNA FL 32446 US	Mailing Address 3009 4TH ST MARIANNA FL 32446 US
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DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 65-0449421	Applied For <input type="checkbox"/> Not Applicable
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6. Name and Address of Current Registered Agent
**ROSEN, SEYMOUR R MD
 3009 4TH ST
 MARIANNA FL 32446**

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

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 _____ (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, 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	D ROSEN, SEYMOUR R MD 3009 4TH ST MARIANNA FL	<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
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
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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 another like empowered.

SIGNATURE: Seymour R. Rosen MD Seymour R. Rosen, MD / 3/02 (850) 526 3937
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/01)