

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 27, 2002 8:00 am
Secretary of State

03-27-2002 90088 011 ***150.00

DOCUMENT # P94000002457

1. Entity Name
COCONUT GROVE MEDICAL CORPORATION

Principal Place of Business 2250 S DIXIE HWY SILVER BLUFF MEDICAL CENTER COCONUT GROVE FL 33133	Mailing Address 2250 S DIXIE HWY SILVER BLUFF MEDICAL CENTER COCONUT GROVE FL 33133
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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 **65-0470484** Applied For
 Not Applicable

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

DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent 7. Name and Address of New Registered Agent

**PAIGE, ROBERT E ESQ
 2151 LEJEUNE RD
 SUITE 309-A
 CORAL GABLES FL 33134**

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 _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	D <input type="checkbox"/> Delete
NAME	JOHNSON, MICHAEL E MD
STREET ADDRESS	2250 S DIXIE HWY SILVER BLUFF MEDICAL CTR
CITY-ST-ZIP	COCONUT GROVE FL 33133
TITLE	D <input checked="" type="checkbox"/> Delete
NAME	JOHNSON, LINDA M
STREET ADDRESS	2250 S DIXIE HWY SILVER BLUFF MEDICAL CTR
CITY-ST-ZIP	COCONUT GROVE FL 33133
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

TITLE	D <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	Hughes, Andrea Kelly
STREET ADDRESS	2250 S. DIXIE HWY, Silver Bluff Medical Center
CITY-ST-ZIP	Coconut Grove, FL 33133
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/15/02 305 856 8170
 Date Daytime Phone #

02/11/02 AM CR2E03/9/01