

**2000 UNIFORM BUSINESS REPORT (UBR)**

**FILED**  
**Feb 04, 2000 8:00 am**  
**Secretary of State**

02-04-2000 90016 023 \*\*\*150.00

**DOCUMENT # P94000035258**

1. Entity Name  
**SOUTHEAST VOLUSIA COUNTY MEDICAL ASSOICATES, P.A**

Principal Place of Business 501 LIVE OAK NEW SMYRNA BEACH FL 32168	Mailing Address 350 NORTH CAUSEWAY 40 BELOTE CPAS NEW SMYRNA BEACH FL 32169-5233
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00016000



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 **59-3253271** Applied For  Not Applicable

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

**6. Name and Address of Current Registered Agent**

**7. Name and Address of New Registered Agent**

**TOUB, FRANK W**  
**501 LIVE OAK**  
**NEW SMYRNA BEACH FL 32168**

Name
Street Address (P.O. Box Number is Not Acceptable)
City
State <b>FL</b>
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, 2000 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	<b>D</b>	<input type="checkbox"/> Delete
NAME	<b>TOUB, FRANK W M.D.</b>	
STREET ADDRESS	<b>501 LIVE OAK</b>	
CITY-ST-ZIP	<b>NEW SMYRNA BEACH FL 32168</b>	
TITLE	<b>T</b>	<input type="checkbox"/> Delete
NAME	<b>SCHILDECKER, CHARLES W MD</b>	
STREET ADDRESS	<b>401 DOWNING 508 PALMETTO</b>	
CITY-ST-ZIP	<b>NEW SMYRNA BEACH FL 32168</b>	
TITLE	<b>VP</b>	<input type="checkbox"/> Delete
NAME	<b>ROSEMUND, R-ERIC MD</b>	
STREET ADDRESS	<b>420 PALMETTO 508 PALMETTO</b>	
CITY-ST-ZIP	<b>NEW SMYRNA BEACH FL 32168</b>	
TITLE	<b>P</b>	<input type="checkbox"/> Delete
NAME	<b>CREWE, BRUCE H MD</b>	
STREET ADDRESS	<b>812 W, INDIAN RIVER BLVD.</b>	
CITY-ST-ZIP	<b>EDGEWATER FL 32132</b>	
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"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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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**

Date \_\_\_\_\_ Daytime Phone # \_\_\_\_\_