

2001 UNIFORM BUSINESS REPORT (UBR)

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DOCUMENT # P94000042156

1. Entity Name
MACON PRIMARY CARE, INC.

FILED

01 APR 26 AM 9:14

SECRETARY OF STATE
TALLAHASSEE FLORIDA



DO NOT WRITE IN THIS SPACE

Principal Place of Business
**4506 L.B. MCLEOD ROAD, SUITE F
ORLANDO FL 32811**

Mailing Address
**P.O. BOX 53-6576
ORLANDO FL 32853-6576**

2600 Technology Dr. P.O. Box 53-6576

Suite 300 etc. Suite, Apt. #, etc.

Orlando, FL Orlando, FL

32804 USA 32853-6576 USA

4. FEI Number **59-3250369** 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

**CORPORATION SERVICE COMPANY
1201 HAYS STREET
TALLAHASSEE FL 32301**

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, 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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	DP	<input type="checkbox"/> Delete
NAME	GRIGGS, STEPHEN P	
STREET ADDRESS	4506 L.B. MCLEOD ROAD, SUITE F	
CITY-ST-ZIP	ORLANDO FL 32811	
TITLE	VP	<input type="checkbox"/> Delete
NAME	ZIOMEK, JANET L	
STREET ADDRESS	4506 L.B. MCLEOD RD., SUITE F	
CITY-ST-ZIP	ORLANDO FL 32811	
TITLE	S	<input type="checkbox"/> Delete
NAME	NOVELL, N. SCOTT	
STREET ADDRESS	4506 L.B. MCLEOD RD., SUITE F	
CITY-ST-ZIP	ORLANDO FL 32811	
TITLE	D	<input type="checkbox"/> Delete
NAME	LEVIN, MARC	
STREET ADDRESS	910 RIDGEBROOK ROAD	
CITY-ST-ZIP	SPARKS GLENCOE MD 21152	
TITLE	D	<input type="checkbox"/> Delete
NAME	ELKINS, MARSHALL	
STREET ADDRESS	910 RIDGEBROOK ROAD	
CITY-ST-ZIP	SPARKS GLENCOE MD 21152	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

TITLE	Stephen D. Linehan	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	2600 Technology Dr., Suite 300	
STREET ADDRESS	Orlando, FL 32804	
CITY-ST-ZIP		
TITLE		<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	2600 Technology Dr., Suite 300	
STREET ADDRESS	Orlando, FL 32804	
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		

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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.

4/20/2001 (407) 822-4600

SIGNATURE: _____
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date Daytime Phone #

CR2E034 (10/00)

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ACCOUNT NO. : 072100000032
REFERENCE : 129440 7120726
AUTHORIZATION : *Patricia Pigato*
COST LIMIT : \$ 150.00

ORDER DATE : April 26, 2001
ORDER TIME : 1:29 PM
ORDER NO. : 129440-105
CUSTOMER NO: 7120726
CUSTOMER: Ms. Dawn Dreghorn
Rotech Medical Corporation
Suite 300
2600 Technology Drive
Orlando, FL 32804

RECEIVED
DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
2001 APR 26 PM 3:12
NOT INTENDED
TO ACKNOWLEDGE
SUFFICIENCY OF FILING

ANNUAL REPORT FILING

NAME: MACON PRIMARY CARE, INC.

XX ANNUAL REPORT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

- CERTIFIED COPY
- XX PLAIN STAMPED COPY
- CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Sandra Mathis EXT 1165

EXAMINER'S INITIALS: *[Signature]*