

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P94000070004

1. Entity Name

MID FLORIDA MEDICAL, INC.

FILED
Jul 19, 2000 8:00 am
Secretary of State

07-19-2000 90152 014 ***150.00

Principal Place of Business

174-B SEMORAN COMMERCE PL
SUITE 114
APOPKA FL 32703
US

Mailing Address

P O BOX 953294
LAKE MARY FL 32795-3294
US

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 **59-3304383**

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

KNIGHT, GARY
138 WEATHERSFIELD AVE N
ALTAMONTE SPRINGS FL 32714

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

Signature, typed or printed name of registered agent and title if applicable.

(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 \$550.00
After SEPTEMBER 13, 2000 Min. will be \$750.00
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 NAME STREET ADDRESS CITY-ST-ZIP	PST KNIGHT, GARY 138 WEATHERSFIELD AVE N ALTAMONTE SPRINGS FL 32714	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

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
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (5/00)



Mid
Florida
Medical

174B Semoran Commerce PL, Suite #114
Apopka, FL 32703
Phone: 407-814-8202
Fax: 407-814-8228

ATTACHMENT

P94000070004

00103422

To Whom It May Concern:

Mid Florida Medical never received any form prior to May 1, 2000. We have been incorporated for over eight years and have never changed our address. Only the president of the company has the key to the PO box in which this form was received just last week. I spoke with someone from your department they instructed us to type this letter explaining this and to send in a check for \$150.00. I am very surprised that a second notice is sent out after the May due date. We obviously never received the other form for in no way shape or form would we file late since there have been no changes. If you have any questions feel free to call our office at (407) 814-8202.

Sincerely,

Gary Knight