

2001 UNIFORM BUSINESS REPORT (UBR)**FILED**
Jan 10, 2001 8:00 am
Secretary of State

01-10-2001 90001 001 ***150.00

00001000



DO NOT WRITE IN THIS SPACE

| | | | |
|--|--|---|---|
| DOCUMENT # P95000074643 | | | |
| 1. Entity Name ARTHRITIS & RHEUMATISM ASSOCIATES, P.A. | | | |
| Principal Place of Business 520 D STREET SUITE C CLEARWATER FL 34616 | | Mailing Address 520 D STREET SUITE C CLEARWATER FL 34616 | |
| 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 59-3337044 | | <input type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable | |
| 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required | | | |
| 6. Name and Address of Current Registered Agent | | 7. Name and Address of New Registered Agent | |
| GASSMAN, ALAN S ESQ. 1245 COURT STREET, SUITE 102 CLEARWATER FL 34616 | | 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. <input type="checkbox"/> (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. <input type="checkbox"/> \$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 | D ROSEN, ADAM M MD 520 D STREET SUITE C CLEARWATER FL 34616 | <input type="checkbox"/> Delete | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | | <input type="checkbox"/> Delete | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
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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. | | | |
| SIGNATURE: _____ | | ADAM M ROSEN MD 1/3/01 727 4436400 | |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR | | Date Daytime Phone # | |

CR2E034 (10/00)