

# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**May 09, 2000 8:00 am**  
**Secretary of State**

05-09-2000 90140 013 \*\*\*150.00

DOCUMENT # P96000007208

1. Entity Name  
**UNITED PHYSICIANS OF CENTRAL FLORIDA, INC.**

Principal Place of Business Mailing Address  
**600 North Boulevard West 200 S. Orange Avenue**  
**Suite C Suite 2300**  
**Leesburg, Fl 34748 SunTrust Center**  
**Orlando, Fl 32802**

2. Principal Place of Business 3. Mailing Address

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

City & State City & State

Zip Country Zip Country

4. FEL Number  
**59-3366701**

Applied For  
Not Applicable

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

6. Name and Address of Current Registered Agent

**A.G.C. Co.**  
**200 South Orange Avenue**  
**Suite 2300, SunTrust Center**  
**Orlando, Florida 32802**

7. Name and Address of New Registered Agent

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

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	D	<input type="checkbox"/> Delete
NAME	Cowin, John, A. M.D.	
STREET ADDRESS	600 North Boulevard West	
CITY-ST-ZIP	Leesburg, Fl 34748	
TITLE	D	<input type="checkbox"/> Delete
NAME	Sustarsic, David, M.D.	
STREET ADDRESS	601 E. Dixie Avenue, Plaza 801	
CITY-ST-ZIP	Leesburg, Fl 34748	
TITLE	D	<input type="checkbox"/> Delete
NAME	Hawk, Steven, E. M.D.	
STREET ADDRESS	791 N. Palmetto Street	
CITY-ST-ZIP	Leesburg, Fl 34748	
TITLE	D	<input type="checkbox"/> Delete
NAME	Puglia, Jacquelyn, E. M.D.	
STREET ADDRESS	110 E. North Boulevard	
CITY-ST-ZIP	Leesburg, Fl 34748	
TITLE	D	<input type="checkbox"/> Delete
NAME	Wheeler, Russ	
STREET ADDRESS	913 North Blvd., East, Ste. B	
CITY-ST-ZIP	Leesburg, Fl 34748	
TITLE	D	<input type="checkbox"/> Delete
NAME	Ismail Akram, M.D.	
STREET ADDRESS	8110 CR 44 Leg A	
CITY-ST-ZIP	Leesburg, Fl 34788	

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	
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 #

CR2E034 (9/99)