

FILE NOW: FILING FEE AFTER MAY 1ST IS \$550.00

PROFIT
CORPORATION
ANNUAL REPORT
1999



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
Mar 06, 1999 8:00 am
Secretary of State

03-06-1999 90081 033 ***150.00

DOCUMENT # **P96000025130**

1. Corporation Name

UROLOGY CLINICS OF FLORIDA, P.A.



Principal Place of Business

**710 LOMAX STREET
JACKSONVILLE FL 32204**

Mailing Address

**1725 BLANDING BLVD
STE 105
JAX FL 32210
US**

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified

03/21/1996

2. Principal Place of Business

2a. Mailing Address

21

26

Suite, Apt. #, etc.

Suite, Apt. #, etc.

22

27

City & State

City & State

23

28

Zip Country

Zip Country

24

25

29

30

4. FEI Number

59-3367197

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution ☐

\$5.00 May Be
Added to Fees

8. This corporation owes the current year Intangible
Personal Property Tax. ☐ Yes ☐ No

9. Name and Address of Current Registered Agent

**JOHN, JIM
1725 BLANDING BLVD
STE 105
JAX FL 32210**

10. Name and Address of New Registered Agent

81 Name

KAELIN, JAMES E M.D.

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

TITLE	D	<input checked="" type="checkbox"/> DELETE
NAME	SAPOLSKY, JACK L M.D.	
STREET ADDRESS	710 LOMAX STREET	
CITY-ST-ZIP	JACKSONVILLE FL 32204	
TITLE	PD	<input type="checkbox"/> DELETE
NAME	BURT, JAMES N M.D.	
STREET ADDRESS	710 LOMAX STREET	
CITY-ST-ZIP	JACKSONVILLE FL 32204	
TITLE	D	<input type="checkbox"/> DELETE
NAME	CRUM, PAUL M M.D.	
STREET ADDRESS	710 LOMAX STREET	
CITY-ST-ZIP	JACKSONVILLE FL 32204	
TITLE	D	<input type="checkbox"/> DELETE
NAME	WHITTAKER, JOHN R M.D.	
STREET ADDRESS	710 LOMAX STREET	
CITY-ST-ZIP	JACKSONVILLE FL 32204	
TITLE	D	<input type="checkbox"/> DELETE
NAME	BALDOCK, JAMES A M.D.	
STREET ADDRESS	710 LOMAX STREET	
CITY-ST-ZIP	JACKSONVILLE FL 32204	
TITLE		<input type="checkbox"/> DELETE
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE	PD	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
1.2 NAME	KAELIN, JAMES E M.D.	
1.3 STREET ADDRESS	1725 BLANDING BLVD STE 105	
1.4 CITY-ST-ZIP	JACKSONVILLE, FL 32210	
2.1 TITLE	D	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
2.2 NAME		
2.3 STREET ADDRESS		
2.4 CITY-ST-ZIP		
3.1 TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
3.2 NAME		
3.3 STREET ADDRESS		
3.4 CITY-ST-ZIP		
4.1 TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
4.2 NAME		
4.3 STREET ADDRESS		
4.4 CITY-ST-ZIP		
5.1 TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
5.2 NAME		
5.3 STREET ADDRESS		
5.4 CITY-ST-ZIP		
6.1 TITLE	D	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
6.2 NAME	GONDER, FLOYD S M.D.	
6.3 STREET ADDRESS	1725 BLANDING BLVD STE 105	
6.4 CITY-ST-ZIP	JACKSONVILLE, FL 32210	

14. 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

J. E. KAELIN

J. E. KAELIN M.D.

1/5/99

904-264-8418

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (11/98)