

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 07, 2003 8:00 am**  
**Secretary of State**

04-07-2003 91034 028 \*\*\*150.00

**DOCUMENT # P96000025130**

1. Entity Name  
**UROLOGY CLINICS OF FLORIDA. P.A.**



Principal Place of Business  
**710 LOMAX STREET  
JACKSONVILLE FL 32204**

Mailing Address  
**710 LOMAX STREET  
JACKSONVILLE FL 32204  
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 **59-3367197**

Applied For

Not Applicable

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

☐ CHECK HERE IF MAKING CHANGES



6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**WHITTAKER, JOHN R MD  
710 LOMAX STREET  
JACKSONVILLE FL 32204**

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00  
After May 1, 2003 Fee will be \$550.00  
Make Check Payable to Florida Department of State**

9. Election Campaign Financing Trust Fund Contribution. ☐ **\$5.00 May Be Added to Fees**

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	D	<input type="checkbox"/> Delete
NAME	DALTON, DAVID L	
STREET ADDRESS	710 LOMAX ST	
CITY-ST-ZIP	JACKSONVILLE FL 32204	
TITLE	D	<input type="checkbox"/> Delete
NAME	LEWIS, RICHARD H	
STREET ADDRESS	710 LOMAX ST	
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	PD	<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		

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		

12. 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 10 or Block 11 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 (10/02)