

# 2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P96000054458

1. Entity Name

PAIN CENTERS OF FLORIDA INC.

**FILED**  
**Apr 18, 2000 8:00 am**  
**Secretary of State**

04-18-2000 90216 018 \*\*\*150.00

Principal Place of Business	Mailing Address
1591 S.E. PORT ST. LUCIE BLVD.. SUITE C PORT ST LUCIE FL 34952 US	1591 S.E. PORT ST. LUCIE BLVD.. SUITE C PORT ST LUCIE FL 34952-5480 US

2. Principal Place of Business <i>1837 S.E. Port St. Lucie Blvd</i>	3. Mailing Address <i>Same as #2</i>
Suite, Apt. #, etc.	Suite, Apt. #, etc.

City & State <i>Port St. Lucie, FL</i>	City & State
Zip <i>34952</i>	Country

4. FEI Number <b>65-0741029</b>	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	<b>\$8.75</b> Additional Fee Required

6. Name and Address of Current Registered Agent

EVERETT, STEVEN T  
780 NE 69TH ST, SUITE #1603  
MIAMI FL 33138

7. Name and Address of New Registered Agent

Name *same*

Street Address (P.O. Box Number is Not Acceptable)  
*1837 S.E. Port St. Lucie Blvd*

City *Port St. Lucie* State *FL* Zip Code *34952*

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 *Steven T. Everett, M.D.* *President* *4/11/00*  
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 \$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	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<b>D</b> EVERETT, STEVEN T 780 NE 69TH ST, SUITE #1603 MIAMI FL 33138 <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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: *Steven T. Everett, M.D.* *4/11/00* *(561) 398-8884*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/99)