

# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 27, 2000 8:00 am**  
**Secretary of State**

04-27-2000 90121 044 \*\*\*150.00

**DOCUMENT # P96000054646**

1. Entity Name  
**LULU AMORNMARN, M.D., P.A.**

Principal Place of Business	Mailing Address
9770 OLD BAYMEADOWS RD 129 JAX FL 32256	9770 OLD BAYMEADOWS RD 129 JAX FL 32256-7986 US



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address		4. FEI Number <b>59-3389216</b>		Applied For	
Suite, Apt. #, etc.		Suite, Apt. #, etc.				Not Applicable	
City & State		City & State		5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	
Zip	Country	Zip	Country				

6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent			
<b>AMORNMARN, LULU M.D.</b> <b>9770 OLD BAYMEADOWS RD STE 129</b> <b>JAX FL 32256</b>				Name			
				Street Address (P.O. Box Number is Not Acceptable)			
				City		FL	

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. (See criteria on back) <input checked="" type="checkbox"/>	<b>FILE NOW!!! FEE IS \$150.00</b> <b>After MAY 1, 2000 Fee will be \$550.00</b> <b>Make Check Payable to Department of State</b>	10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/>	\$5.00 May Be Added to Fees
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11. OFFICERS AND DIRECTORS				12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11			
TITLE	P	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	AMORNMARN, LULU M.D.			NAME			
STREET ADDRESS	9770 OLD BAYMEADOWS RD STE 129			STREET ADDRESS			
CITY-ST-ZIP	JAX FL 32256			CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				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 REQUIRED **4/20/2000** **(904) 564-1559**  
 LULU AMORNMARN, M.D.  
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CF 1014 19/99