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Mar 12, 1999 8:00 am
Secretary of State

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PROFIT CORPORATION ANNUAL REPORT 1999		FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # P96000072478

1. Corporation Name
UNIVERSAL PAIN INSTITUTE, INC.

Principal Place of Business
2727 W. VIRGINIA AVENUE
TAMPA FL 33607

Mailing Address
2822 W. VIRGINIA AVE.
TAMPA FL 33607



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		2a. Mailing Address		3. Date Incorporated or Qualified 08/30/1996	
21	Suite, Apt. #, etc.	26	Suite, Apt. #, etc.	4. FEI Number 59-3411214	Applied For Not Applicable
22	City & State	27	City & State	5. Certificate of Status Desired <input checked="" type="checkbox"/>	\$8.75 Additional Fee Required
23	Zip	28	Zip	6. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/>	\$5.00 May Be Added to Fees
24	Country	29	Country	8. This corporation owes the current year Intangible Personal Property Tax. <input type="checkbox"/> Yes <input type="checkbox"/> No	

9. Name and Address of Current Registered Agent

RUGG, JOSEPH W.N.
ONE TAMPA CITY CENTER, SUITE 2100
201 NORTH FRANKLIN STREET
TAMPA FL 33601

10. Name and Address of New Registered Agent

81	Name
82	Street Address (P.O. Box Number is Not Acceptable)
83	
84	City
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		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	DS <input type="checkbox"/> DELETE	1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	ALVAREZ-GIL, FRANK M.D.	1.2 NAME	
STREET ADDRESS	2822 W. VIRGINIA AVENUE	1.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL 33607	1.4 CITY-ST-ZIP	
TITLE	DCEO <input type="checkbox"/> DELETE	2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	WESTBURY, MICHAEL J M.D.	2.2 NAME	
STREET ADDRESS	2822 W. VIRGINIA AVENUE	2.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL 33607	2.4 CITY-ST-ZIP	
TITLE	VP <input type="checkbox"/> DELETE	3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	BAUZYS, RAYMOND J M.D.	3.2 NAME	
STREET ADDRESS	2822 W. VIRGINIA AVENUE	3.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL 33607	3.4 CITY-ST-ZIP	
TITLE	DEVP <input type="checkbox"/> DELETE	4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	ALVAREZ, GEORGE G	4.2 NAME	
STREET ADDRESS	2822 W. VIRGINIA AVENUE	4.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL 33607	4.4 CITY-ST-ZIP	
TITLE	DT <input type="checkbox"/> DELETE	5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	DIEHR, JERRY	5.2 NAME	
STREET ADDRESS	2727 W. VIRGINIA AVENUE	5.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL 33607	5.4 CITY-ST-ZIP	
TITLE	VP <input type="checkbox"/> DELETE	6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	ERBAUGH, DUANE	6.2 NAME	
STREET ADDRESS	2727 W. VIRGINIA AVENUE	6.3 STREET ADDRESS	
CITY-ST-ZIP	TAMPA FL 33607	6.4 CITY-ST-ZIP	

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:

SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

George G. Alvarez, M.D.

1/19/99

813-879-5761

Date

Daytime Phone #

CR2E034 (11/98)