

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P96000083039

1. Entity Name

HEALTH CARE ASSOCIATES OF SARASOTA, P.A.



**FILED**  
**May 01, 2003 8:00 am**  
**Secretary of State**

05-01-2003 90793 030 \*\*\*150.00

0654020 AV

Principal Place of Business

3920 BEE RIDGE ROAD  
BLDG. E, STE. M  
SARASOTA FL 34233

Mailing Address

2822 PROCTOR ROAD  
SUITE A  
SARASOTA FL 34231

60026521



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

☐ CHECK HERE IF MAKING CHANGES

Zip

Country

Zip

Country

4. FEI Number

65-0698911

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75** Additional  
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

HERMANN, CECELIA M  
3920 BEE RIDGE ROAD  
BLDG. E, STE. M  
SARASOTA FL 34233

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  
NAME  
STREET ADDRESS  
CITY - ST - ZIP  
PD  
HERMANN, CECELIA M M.D.  
3920 BEE RIDGE ROAD, BLDG. E, STE. M  
SARASOTA FL 34233 ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY - ST - ZIP ☐ Change ☐ Addition

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

Date

Daytime Phone #

CR2E034 (10/02)