2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P97000098052

1. Entity Name

WELL CARE CLINIC, P.A.

FILED
Apr 14, 2000 8:00 am
Secretary of State
04-14-2000 90014 027 ***150.00

DO NOT WRITE IN THIS SPACE

Principal Place of Business	Mailing Address
WELL CARE CLINIC, P.A. 449-45TH AVE S. ST. PETERSBURG FL 33705	WELL CARE CLINIC, P.A. 449-45TH AVE S. ST. PETERSBURG FL 33705-4510

2. Principal Place of Business	3. Mailing Address
as above	as above
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. FEI Number 59-3476004 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent

HIMANSU, TRIVEDI
501 LAKESIDE VILLAGE
116TH AVENUE NORTH, #304
ST. PETERSBURG FL 33716

7. Name and Address of New Registered Agent

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.

SIGNATURE ______________________ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

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		12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	D ☐ Delete	TITLE	☐ Change ☐ Addition
NAME	HIMANSU, TRIVEDI	NAME	
STREET ADDRESS	501 LAKESIDE VILL., 116TH AVE., #304	STREET ADDRESS	
CITY-ST-ZIP	ST. PETERSBURG FL 33716	CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
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CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	☐ Delete	TITLE	☐ Change ☐ Addition
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	

CR2E034 (9/99)

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: SIGN HT Trivedi 4/4/00 895-9278
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #