

FILED
Feb 25, 2002 8:00 am
Secretary of State

01-21-2002 90048 041 ***150.00

2002 UNIFORM BUSINESS REPORT (UBR)**DOCUMENT # P97000107069**

1. Entity Name

FLORIDA MULTI SPECIALTY MEDICAL GROUP, PROFESSIONAL ASSOCIATION

Principal Place of Business

6501 ARLINGTON EXY

B164-1

JACKSONVILLE FL 32211

Mailing Address

4110 SOUTHPOINT BLVD. #205

JACKSONVILLE FL 32216

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number **59-3487405**

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

~~CAMP, RICHARD CRA~~
~~4110 SOUTHPOINT BLVD.~~
~~SUITE 110~~
~~JACKSONVILLE FL 32216~~

Todd McClerren
6501 ARLINGTON EXY
B164-1
JACKSONVILLE FL 32216

Name

Street Address (P.O. Box Number is Not Acceptable)

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

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, 2002 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 **P** ☐ Delete
 NAME **MCCLERREN, TODD**
 STREET ADDRESS **P.O. BOX 56586**
 CITY-ST-ZIP **JACKSONVILLE FL 32241-6586**

TITLE ☐ Delete
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 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/22/01

Date

(904) 722-1677

Daytime Phone #

CR2E034 (9/01)