

FILED
Apr 26, 1999 8:00 am
Secretary of State

04-26-1999 90082 010 ***150.00

PROFIT CORPORATION ANNUAL REPORT 1999		FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # P98000004178

1. Corporation Name

INTERVENTIONAL PAIN MEDICINE OF GAINESVILLE, P.A

Principal Place of Business
 125 W ROMANA ST. SUITE 224
 PENSACOLA FL 32501

Mailing Address
 125 W ROMANA ST. SUITE 224
 PENSACOLA FL 32501



DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified

01/13/1998

2. Principal Place of Business	2a. Mailing Address
21 Suite, Apt. #, etc.	26 Suite, Apt. #, etc.
22 City & State	27 City & State
23 Zip Country	28 Zip Country
24	29

4. FEI Number
59-3486785Applied For
Not Applicable5. Certificate of Status Desired ☐ \$8.75 Additional Fee Required8. Election Campaign Financing Trust Fund Contribution ☐ \$5.00 May Be Added to Fees8. This corporation owes the current year Intangible Personal Property Tax. ☒ Yes ☐ No

9. Name and Address of Current Registered Agent

LOZIER, DANIEL R
125 W ROMANA ST, SUITE 224
PENSACOLA FL 32501

10. Name and Address of New Registered Agent

81 Name	85 Zip Code
82 Street Address (P.O. Box Number is Not Acceptable)	
83	
84 City	FL

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	<input type="checkbox"/> DELETE	1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	D TIMMONS, RUBEN B	1.2 NAME	
STREET ADDRESS	4412 N-DAVID HWY	1.3 STREET ADDRESS	4412 N Davis Hwy
CITY-ST-ZIP	PENSACOLA FL 32503	1.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	D FAIRLEIGH, DAVIE E	2.2 NAME	
STREET ADDRESS	4412 N DAVIS HWY	2.3 STREET ADDRESS	
CITY-ST-ZIP	PENSACOLA FL 32503	2.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	D BUCHALTER, JEFF L	3.2 NAME	
STREET ADDRESS	4412 N DAVIS HWY	3.3 STREET ADDRESS	
CITY-ST-ZIP	PENSACOLA FL 32503	3.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		4.2 NAME	
STREET ADDRESS		4.3 STREET ADDRESS	
CITY-ST-ZIP		4.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		5.2 NAME	
STREET ADDRESS		5.3 STREET ADDRESS	
CITY-ST-ZIP		5.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		6.2 NAME	
STREET ADDRESS		6.3 STREET ADDRESS	
CITY-ST-ZIP		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: X **SIGNATURE REQUIRED**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

X 4/15/99 Date

X 850-477-5969 Daytime Phone #

CR2E034 (11/98)