

**2003 FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**

DOCUMENT # P98000086472

1. Entity Name

HAWTHORNE MEDICAL CENTER, P.A.



FILED
Feb 19, 2003 8:00 am
Secretary of State

02-19-2003 90163 027 ***150.00

Principal Place of Business
**21815 SOUTHEAST 71ST AVENUE
HAWTHORNE FL 32640
US**

Mailing Address
**21815 SOUTHEAST 71ST AVENUE
HAWTHORNE FL 32640
US**



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 **59-3537283**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

☐ CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**COLASANTE, ONA M.D.
21115 S.E. 179TH PLACE
LOCHLOOSA FL 32662**

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 **D** ☐ Delete
NAME **COLASANTE, ONA M.D.**
STREET ADDRESS **21115 S.E. 179TH PLACE**
CITY-ST-ZIP **LOCHLOOSA FL 32662**

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

TITLE **T** ☐ Delete
NAME **POWELL, DONALD G**
STREET ADDRESS **1863 STATE ROAD 20**
CITY-ST-ZIP **HAWTHORNE FL 32640**

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

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ Change ☐ Addition
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CITY-ST-ZIP

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

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 #

2-12-03 352 481-2400

CR2E034 (10/02)