

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 10, 2003 8:00 am
Secretary of State

02-10-2003 90173 020 ***158.75

DOCUMENT # P98000089413

1. Entity Name
WOLVERINE ANESTHESIA CONSULTANTS, M.D., P.A.



Principal Place of Business
100 W. LUCERNE CIRCLE
SUITE 502
ORLANDO FL 32801

Mailing Address
P.O. BOX 4918
ORLANDO FL 32802-4918

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 59-3537483

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

MURBACH, ROGER S
100 W. LUCERNE CIRCLE
SUITE 502
ORLANDO FL 32801

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 PD **NAME** MURBACH, ROGER S **STREET ADDRESS** 100 W LUCERNE CIRCLE #502 **CITY-ST-ZIP** ORLANDO FL 32801 ☐ Delete

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

TITLE DS **NAME** APPLEBLATT, STEVEN L **STREET ADDRESS** 100 W LUCERNE CIRCLE #502 **CITY-ST-ZIP** ORLANDO FL 32801 ☐ Delete

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

TITLE DT **NAME** STOCKTON, EDWARD A **STREET ADDRESS** 100 W LUCERNE CIRCLE #502 **CITY-ST-ZIP** ORLANDO FL 32801 ☐ Delete

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

TITLE **NAME** **STREET ADDRESS** **CITY-ST-ZIP** ☐ 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 667, 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

2-6-03

407-872-2244

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (10/02)