

**2000 UNIFORM BUSINESS REPORT (UBR)**

**FILED**  
**May 18, 2000 8:00 am**  
**Secretary of State**

05-18-2000 90313 027 \*\*\*150.00

**DOCUMENT # P98000100458**

1. Entity Name  
**MARIANNA OB/GYN ASSOCIATES, P.A.**

|  |   |
|--|---|
| Principal Place of Business<br><b>4230 HOSPITAL DRIVE, SUITE 202<br/>         SUITE 210<br/>         MARIANNA FL 32446</b> | Mailing Address<br><b>4230 HOSPITAL DRIVE, SUITE 202<br/>         SUITE 210<br/>         MARIANNA FL 32446-1927</b> |
|--|---|



DO NOT WRITE IN THIS SPACE

|                                |         |                     |         |   |                |
|--------------------------------|---------|---------------------|---------|---|----------------|
| 2. Principal Place of Business |         | 3. Mailing Address  |         | 4. FEI Number<br><b>59-3537638</b>  | Applied For    |
| Suite, Apt. #, etc.            |         | Suite, Apt. #, etc. |         |   | Not Applicable |
| City & State                   |         | City & State        |         | 5. Certificate of Status Desired <input type="checkbox"/> <b>\$8.75</b> Additional Fee Required |                |
| Zip                            | Country | Zip                 | Country |   |                |

|   |  |  |  |  |          |
|---|--|--|--|--|----------|
| 6. Name and Address of Current Registered Agent<br><br><b>ORIA, GONZALO A<br/>         4230 HOSPITAL DR<br/>         SUITE 210<br/>         MARIANNA FL 32446</b> |  |  | 7. Name and Address of New Registered Agent        |  |          |
|   |  |  | Name   |  |          |
|   |  |  | Street Address (P.O. Box Number is Not Acceptable) |  |          |
|   |  |  | City   |  |          |
|   |  |  | <b>FL</b>  |  | 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) <input type="checkbox"/> | <b>FILE NOW!!! FEE IS \$150.00</b><br><b>After MAY 1, 2000 Fee will be \$550.00</b><br><b>Make Check Payable to Department of State</b> | 10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> <b>\$5.00</b> May Be Added to Fees |
|---|---|--|

| 11. OFFICERS AND DIRECTORS                     |   | 12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 |   |
|--|---|---|---|
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <b>D</b><br><b>ORIA, GONZALO A</b><br><b>4230 HOSPITAL DR STE 210</b><br><b>MARIANNA FL 32446</b> <input type="checkbox"/> Delete | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <b>D</b><br><b>MUNIZ, ORLANDO</b><br><b>4230 HOSPITAL DR STE 210</b><br><b>MARIANNA FL 32446</b> <input type="checkbox"/> Delete  | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition |

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: *Orlando A. Muniz M.D.* Date: 4/30/00  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Daytime Phone #

CR2E034 (9/99)