2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Aug 17, 2001 8:00 am
Secretary of State
08-17-2001 90005 042 ***550.00

DOCUMENT # P98000100458

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

Principal Place of Business	Mailing Address
4230 HOSPITAL DRIVE. SUITE 202 SUITE 210 MARIANNA FL 32446	4230 HOSPITAL DRIVE. SUITE 202 SUITE 210 MARIANNA FL 32446

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	3. Mailing Address
4230 HOSPITAL DRIVE	4230 HOSPITAL DRIVE
Suite, Apt. #, etc.: SUITE 209	Suite, Apt. #, etc.: SUITE 209
City & State: MARIANNA FL	City & State: MARIANNA FL
Zip: 32446 Country:	Zip: 32446 Country:

4. FEI Number 59-3537638 ☐ 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
ORIA, GONZALO A 4230 HOSPITAL DR SUITE 210 MARIANNA FL 32446	Name: Street Address (P.O. Box Number is Not Acceptable): SUITE 209 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.

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, 2001 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 / NAME / STREET ADDRESS / CITY-ST-ZIP	D ORIA, GONZALO A 4230 HOSPITAL DR STE 210 MARIANNA FL 32446 ☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☑ Change ☐ Addition 4230 HOSPITAL DR STE 209
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	D MUNIZ, ORLANDO 4230 HOSPITAL DR STE 210 MARIANNA FL 32446 ☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☑ Change ☐ Addition 4230 HOSPITAL DR STE 209
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Delete	TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	☐ Change ☐ Addition
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CR2E034 (10/00)

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] MD. 8/15/01 850-482-1484
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #