

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Jan 28, 2003 8:00 am
Secretary of State

01-28-2003 90081 022 ***150.00

DOCUMENT # P98000100458



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

Principal Place of Business
**4230 HOSPITAL DRIVE
SUITE 209
MARIANNA FL 32446
US**

Mailing Address
**4230 HOSPITAL DRIVE
SUITE 209
MARIANNA FL 32446
US**



CHECK HERE IF MAKING CHANGES

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

6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent							
ORIA, GONZALO A 4230 HOSPITAL DR SUITE 209 MARIANNA FL 32446				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 _____ (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	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	ORIA, GONZALO A			NAME			
STREET ADDRESS	4230 HOSPITAL DR STE 209			STREET ADDRESS			
CITY-ST-ZIP	MARIANNA FL 32446			CITY-ST-ZIP			
TITLE	D	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	MUNIZ, ORLANDO			NAME			
STREET ADDRESS	4230 HOSPITAL DR STE 209			STREET ADDRESS			
CITY-ST-ZIP	MARIANNA FL 32446			CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				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]* **FILED** **1/27/03** **850-482-6484**
SIGNATURE, TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/02)