

2000 UNIFORM BUSINESS REPORT (UBR)

8/

FILED
Aug 17, 2000 8:00 am
Secretary of State

08-03-2000 90003 025 ***558.75

DOCUMENT # P98000104520

1. Entity Name

A. B. ROA MEDICAL CENTER, P.A.

Principal Place of Business

201 U.S. HIGHWAY 27 SOUTH
 LAKE PLACID FL 33852

Mailing Address

A. B. ROA Medical Center, P.A.

201 U.S. HIGHWAY 27 SOUTH
 LAKE PLACID FL 33852-2829

P.O. Box 2829

Lake Placid, FL 33862-2829

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number

65-0884511

Applied For

Not Applicable

Zip

Country

Zip

Country

5. Certificate of Status Desired ☐

\$8.75 Additional
 Fee Required

DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

ROA, ANTONIO B M.D.
 201 U.S. HIGHWAY 27 SOUTH
 LAKE PLACID FL 33852

A. B. ROA Medical Center, P.A.

P.O. Box 2829

Lake Placid, FL 33862-2829

Name

Street Address (P.O. Box Number is Not Acceptable)

201 U.S. Hwy 27 South

Lake Placid, FL 33862-2829

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, 2000 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	OP ROA, ANTONIO B M.D. 201 U.S. HWY 27 SOUTH LAKE PLACID FL 33852	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Delete

TITLE NAME STREET ADDRESS CITY - ST - ZIP	201 US Hwy 27 South P.O. Box 2829 Zip Code 33862-2829	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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TITLE NAME STREET ADDRESS CITY - ST - ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS 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

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

2-4-00 (863) 465-6200

CR 20034 (9/99)