

2002 UNIFORM BUSINESS REPORT (UBR)

0128602 AT

DOCUMENT # P98000104520

1. Entity Name
A. B. ROA MEDICAL CENTER, P.A.

FILED

02 NOV 26 PM 5:31

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



REINSTATEMENT 2002

Principal Place of Business
P.O. BOX 2829
LAKE PLACID FL 33862-2829

Mailing Address
PO BOX 2829
LAKE PLACID FL 33862

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

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

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 *AB Roa / Rene C. Roa, Office Manager & Co. Owner*
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 \$550.00
After September 13, 2002 Fee will be \$750.00
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 ☐ Delete

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
700008816597 ☐ Change ☐ Addition
11/06/02--01005--022 **750.00

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP ☐ 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

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP ☐ 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

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP ☐ Delete

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP ☐ Change ☐ 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: *AB Roa* SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (4/02)