2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P99000016128

1. Entity Name

GALLOWAY MEDICAL SURGICAL CENTER, INC.

FILED
May 17, 2000 8:00 am
Secretary of State
05-17-2000 90860 016 ***158.75

Principal Place of Business	Mailing Address
825 SW 87TH AVE.. SUITE I MIAMI FL 33174	825 SW 87TH AVE.. SUITE I MIAMI FL 33174-3253

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 65-0905931 ☐ 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
CRUZ, ARMANDO 825 SW 87TH AVE., SUITE I MIAMI FL 33174	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.

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	PTD	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	CRUZ, ROBERTO		NAME	
STREET ADDRESS	825 SW 87TH AVE., SUITE I		STREET ADDRESS	
CITY-ST-ZIP	MIAMI FL 33174		CITY-ST-ZIP	
TITLE	VSD	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	CRUZ, ARMANDO		NAME	
STREET ADDRESS	825 SW 87TH AVE., SUITE I		STREET ADDRESS	
CITY-ST-ZIP	MIAMI FL 33174		CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	

CR2E034 (9/99)

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: ARMANDO CRUZ, M.D. 4/19/2000 305-266-8746
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #