

2002-UNIFORM-BUSINESS-REPORT (UBR)

FILED
Jul 29, 2002 8:00 am
Secretary of State

07-29-2002 90007 023 ***550.00

DOCUMENT # P99000016128

1. Entity Name
GALLOWAY MEDICAL SURGICAL CENTER, INC.

Principal Place of Business
 825 SW 87TH AVE., SUITE I
 MIAMI FL 33174

Mailing Address
 825 SW 87TH AVE., SUITE I
 MIAMI FL 33174



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

~~CRUZ, ARMANDO~~
 825 SW 87TH AVE., SUITE I
 MIAMI FL 33174

7. Name and Address of New Registered Agent

Name Roberto Cruz
 Street Address (P.O. Box Number is Not Acceptable)
825 SW 87th Ave Suite I
 City Miami FL Zip Code 33174

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

7-23-02

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 **\$5.00 May Be Added to Fees**
Trust Fund Contribution

11. OFFICERS AND DIRECTORS		12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE	PTD	TITLE	
NAME	CRUZ, ROBERTO	NAME	
STREET ADDRESS	825 SW 87TH AVE., SUITE I	STREET ADDRESS	
CITY-ST-ZIP	MIAMI FL 33174	CITY-ST-ZIP	
	<input type="checkbox"/> Delete		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE	VSD	TITLE	
NAME	CRUZ, ARMANDO	NAME	
STREET ADDRESS	825 SW 87TH AVE., SUITE I	STREET ADDRESS	
CITY-ST-ZIP	MIAMI FL 33174	CITY-ST-ZIP	
	<input type="checkbox"/> Delete		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
	<input type="checkbox"/> Delete		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
	<input type="checkbox"/> Delete		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
	<input type="checkbox"/> Delete		<input type="checkbox"/> Change <input type="checkbox"/> Addition

CR2E034 (4/02)

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 REQUIRED
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

305-861-1667
 Daytime Phone #