2001 UNIFORM BUSINESS REPORT (UBR)

4/19

FILED
May 18, 2001 8:00 am
Secretary of State
04-19-2001 90328 005 ***150.00

DOCUMENT # P99000023660

1. Entity Name
SOUTH FLORIDA MEDICAL ONCOLOGY CENTERS, INC.

Principal Place of Business	Mailing Address
4081 TAMIAMI TRAIL NORTH STE. C-101 NAPLES FL 34103	4081 TAMIAMI TRAIL NORTH STE. C-101 NAPLES FL 34103

[redacted]

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 APPLIED FOR ☑ 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
BURANDT, ROBERT B 1714 CAPE CORAL PARKWAY EAST CAPE CORAL FL 33910	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, 2001 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	D BURANDT, ROBERT B 1714 CAPE CORAL PARKWAY EAST CAPE CORAL FL 33904	☐ 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
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition

CR2E034 (10/00)

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: S M Shindore S. M. Shindore 4/10/01 941-435-1444
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Attachment 44404

Form **SS-4**
(Rev. February 1998)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, certain individuals, and others. See instructions.)

▶ Keep a copy for your records.

EIN #591000023360

OMB No. 1545-0003

Please type or print clearly.

1 Name of applicant (legal name) (see instructions)
South Florida Medical Oncology Centers Inc.

2 Trade name of business (if different from name on line 1)

3 Executor, trustee, "care of" name

4a Mailing address (street address) (room, apt., or suite no.)
4081 Tamiami Trail North

5a Business address (if different from address on lines 4a and 4b)
—

4b City, state, and ZIP code
Naples FL 34103

5b City, state, and ZIP code
—

6 County and state where principal business is located
Collier County Florida

7 Name of principal officer, general partner, grantor, owner, or trustor—SSN or ITIN may be required (see instructions) ▶

8a Type of entity (Check only one box.) (see instructions)
Caution: *If applicant is a limited liability company, see the instructions for line 8a.*

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ REMIC
- ☐ State/local government
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☐ Other (specify) ▶
- ☐ Personal service corp.
- ☐ National Guard
- ☐ Farmers' cooperative
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (SSN)
- ☒ Other corporation (specify) ▶ Medical Practice
- ☐ Trust
- ☐ Federal government/military
- (enter GEN if applicable)

8b If a corporation, name the state or foreign country (if applicable) where incorporated — State: Florida. USA — Foreign country:

9 Reason for applying (Check only one box.) (see instructions)
- ☒ Started new business (specify type) ▶
- ☐ Hired employees (Check the box and see line 12.)
- ☐ Created a pension plan (specify type) ▶
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Other (specify) ▶

10 Date business started or acquired (month, day, year) (see instructions)
1st April 2000

11 Closing month of accounting year (see instructions)
December

12 First date wages or annuities were paid or will be paid (month, day, year). **Note:** *If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)* ▶ May 30th, 2001

13 Highest number of employees expected in the next 12 months. **Note:** *If the applicant does not expect to have any employees during the period, enter -0-. (see instructions)* ▶	Nonagricultural	Agricultural	Household
	4		

14 Principal activity (see instructions) ▶ Medical Practice

15 Is the principal business activity manufacturing? ☐ Yes ☒ No
If "Yes," principal product and raw material used ▶

16 To whom are most of the products or services sold? Please check one box.
☒ Public (retail) ☐ Other (specify) ▶ ☒ Business (wholesale) ☐ N/A

17a Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☒ No
Note: *If "Yes," please complete lines 17b and 17c.*

17b If you checked "Yes" on line 17a, give applicant's legal name and trade name shown on prior application, if different from line 1 or 2 above.
Legal name ▶ Trade name ▶

17c Approximate date when and city and state where the application was filed. Enter previous employer identification number if known.

Approximate date when filed (mo., day, year)	City and state where filed	Previous EIN

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Business telephone number (include area code): 941-435-1444

Fax telephone number (include area code): 941-649-6211

Name and title (Please type or print clearly.) ▶ Shreelal M. Shindore, M.D. Director

Signature ▶ SM Shindore

Date ▶ 5/1/2001

Note: *Do not write below this line. For official use only.*

Please leave blank ▶	Geo.	Ind.	Class	Size	Reason for applying