

2000 UNIFORM BUSINESS REPORT (UBR)**FILED****Apr 11, 2000 8:00 am**
Secretary of State

04-11-2000 90230 041 ***150.00

DOCUMENT # P99000032368

1. Entity Name

GERIATRIC MEDICAL ASSOCIATES, INC.

Principal Place of Business

**633 WARD AVENUE
BROOKSVILLE FL 34601**

Mailing Address

**633 WARD AVENUE
BROOKSVILLE FL 34601-1946**

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number

59-3568197

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

**CUMMINGS, JAMES R
675 HARVARD STREET
BROOKSVILLE FL 34601**

7. Name and Address of New Registered Agent

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

TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	<input type="checkbox"/> Delete
NAME	
STREET ADDRESS	
CITY - ST - ZIP	

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	P James R. Cummings, M.D.
STREET ADDRESS	605 LAMAR AVENUE
CITY - ST - ZIP	BROOKSVILLE, FL 34601
TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	V/A Monte Edwards
STREET ADDRESS	605 LAMAR AVE.
CITY - ST - ZIP	BROOKSVILLE, FL 34601
TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	V/A C. William Cosner
STREET ADDRESS	633 WARD AVE.
CITY - ST - ZIP	BROOKSVILLE, FL 34601
TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	V/A/S/T Judith D. Lyons
STREET ADDRESS	633 WARD AVE.
CITY - ST - ZIP	BROOKSVILLE, FL 34601
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	
STREET ADDRESS	
CITY - ST - ZIP	

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:**Judith D. Lyons**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR**1-14-00**
Date**352-799-5411**
Daytime Phone #

CR2E034 (9/99)