

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Feb 25, 2003 8:00 am**  
**Secretary of State**

02-25-2003 90123 037 \*\*\*150.00

**DOCUMENT # P99000111399**

1. Entity Name  
**SOUTH LAKE ANESTHESIA SERVICES, P.A.**



Principal Place of Business  
**17137 MAGNOLIA ISLAND BLVD  
CLERMONT FL 34711  
US**

Mailing Address  
**17137 MAGNOLIA ISLAND BLVD  
CLERMONT FL 34711  
US**



2. Principal Place of Business

**17137 MAGNOLIA ISLAND BLVD**  
Suite, Apt. #, etc.

3. Mailing Address

**17137 MAGNOLIA ISLAND BLVD**  
Suite, Apt. #, etc.

☐ CHECK HERE IF MAKING CHANGES

City & State  
**CLERMONT, FL**  
Zip  
**34711**  
Country  
**USA**

City & State  
**CLERMONT, FL**  
Zip  
**34711**  
Country  
**USA**

4. FEI Number  
**59-3613830**

Applied For  
☐ Not Applicable

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent

**GHIVIZZANI, DAVID S MD  
17137 MAGNOLIA ISLAND BLVD  
CLERMONT FL 34711**

7. Name and Address of New Registered Agent

Name  
**GHIVIZZANI, DAVID S MD**  
Street Address (P.O. Box Number is Not Acceptable)  
**17137 MAGNOLIA ISLAND BLVD**  
City  
**CLERMONT** FL Zip Code  
**34711**

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 \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

**FILE NOW!!! FEE IS \$150.00**  
**After May 1, 2003 Fee will be \$550.00**  
**Make Check Payable to Florida Department of State**

9. Election Campaign Financing  
Trust Fund Contribution. ☐ **\$5.00 May Be Added to Fees**

10. OFFICERS AND DIRECTORS

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
**D  
GHIVIZZANI, DAVID S MD  
17137 MAGNOLIA ISLAND BLVD  
CLERMONT FL 34711** ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
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CITY-ST-ZIP ☐ Delete

TITLE  
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CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

12. 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 10 or Block 11 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

**2/20/03**  
Date Daytime Phone #

CR2E034 (10/02)