

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 23, 2001 8:00 am
Secretary of State

04-23-2001 90143 019 ***150.00

DOCUMENT # S69281

1. Entity Name
INSIGNIA CARE FOR WOMEN, P.A.

Principal Place of Business

**2123 WEST M.L.K.
TAMPA FL 33607
US**

Mailing Address

**2123 WEST M.L.K.
TAMPA FL 33607
US**

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 **59-3083527**

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

**BERGMANN, CHARLES
ONE URBAN CENTER, SUITE 250
4830 WEST KENNEDZ BLVD.
TAMPA FL 33609**

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/T NEWTON, WILLIAM A. M.D. 1019 SWANN AVENUE TAMPA FL 33607 (change) | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | D/VP WILKERSON, W. GREGORY MD 1019 SWANN AVENUE TAMPA FL 33607 (change) | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | D/P VON THRON, JAMES C. M.D. 2123 WEST BUFFALO AVENUE TAMPA FL 33607 (change) | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | D/S GARCIA, JAY J. M.D. 2123 WEST BUFFALO AVENUE TAMPA FL 33607 (change) | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | VP of operations RS ARMSTRONG MD 2123 W OR MLK JR BLVD TAMPA, FL 33607 (ADD) | <input type="checkbox"/> Delete |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | VP of Finance GALEN B JONES MD. 2123 W OR MLK JR BLVD TAMPA, FL 33607 (ADD) | <input type="checkbox"/> Delete |

| | | |
|--|--|--|
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | VP of Personnel STEVEN L. GREENBERG MD 2123 W. OR MLK JR BLVD TAMPA, FL 33607 | <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
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| TITLE NAME STREET ADDRESS CITY-ST-ZIP | | <input type="checkbox"/> Change <input type="checkbox"/> Addition |

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

GALEN B. JONES MD

Date

Daytime Phone #

CR2E034 (10/00)