

2000 UNIFORM BUSINESS REPORT (UBR)

FILED
May 08, 2000 8:00 am
Secretary of State

05-08-2000 90027 043 ***150.00

DOCUMENT # **V07361**

1. Entity Name
SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE, P.

Principal Place of Business RIVERSIDE DR SUITE 302 FL 34994	Mailing Address 509 RIVERSIDE DR SUITE 302 STUART FL 34994-2579 US
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DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address		4. FEI Number 65-0311858		Applied For	
Suite, Apt. #, etc.		Suite, Apt. #, etc.		Not Applicable			
City & State		City & State		5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	
Zip	Country	Zip	Country				

6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent							
COEL, MARK A 4000 HOLLYWOOD BLVD. SUITE 350 NORTH HOLLYWOOD FL 33021				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) <input type="checkbox"/>	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. <input type="checkbox"/>	\$5.00 May Be Added to Fees
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11. OFFICERS AND DIRECTORS				12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11			
TITLE	PD	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	ANSPACH, W.E. III M.D.			NAME			
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302			STREET ADDRESS			
CITY-ST-ZIP	STUART FL 34994			CITY-ST-ZIP			
TITLE	VD	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	CARLSON, W.E. M.D.			NAME			
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302			STREET ADDRESS			
CITY-ST-ZIP	STUART FL 34994			CITY-ST-ZIP			
TITLE	SD	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	DESMAN, SCOTT M.D.			NAME			
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302			STREET ADDRESS			
CITY-ST-ZIP	STUART FL 34994			CITY-ST-ZIP			
TITLE	TD	<input checked="" type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	KIM, DAVID M.D.			NAME			
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302			STREET ADDRESS			
CITY-ST-ZIP	STUART FL 34994			CITY-ST-ZIP			
TITLE	D	<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	HAAS, GEORGE M.D.			NAME			
STREET ADDRESS	509 RIVERSIDE DRIVE SUITE 302			STREET ADDRESS			
CITY-ST-ZIP	STUART FL 34994			CITY-ST-ZIP			
TITLE		<input type="checkbox"/> Delete		TITLE		<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME				NAME			
STREET ADDRESS				STREET ADDRESS			
CITY-ST-ZIP				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: SIGNATURE REQUIRED ANSPACH 4-20-00 5612235580
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/99)