

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # V07883

1. Entity Name

WILLIAM B. THOMPSON, JR., M.D., P.A.

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

03-08-2000 90079 014 ***150.00

Principal Place of Business

WALLIS MEDICAL CENTER
40 SW 12TH ST., SUITE A-102
OCALA FL 34474

Mailing Address

WALLIS MEDICAL CENTER
40 SW 12TH ST., SUITE A-102
OCALA FL 34474-4056

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number

59-3169327

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

7. Name and Address of New Registered Agent

MACQUARRIE, CHRISTOPHER J.
2303 SE 17TH ST.
SUITE 201
OCALA FL 32671

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

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	D	<input type="checkbox"/> Delete
NAME	THOMPSON, WILLIAM B., JR	
STREET ADDRESS	40 SW 12TH ST., #A-102	
CITY-ST-ZIP	OCALA FL	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
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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: *W.B. Thompson MD PA*
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

3/6/00 352-732-5042
Date Daytime Phone #

CR2E034 (9/99)