

# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

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

08-25-2003 90098 049 \*\*\*150.00

**DOCUMENT # V27348**

**1. Entity Name**  
**SOUTH MEDICAL PROFESSIONAL GROUP, INC.**



**Principal Place of Business**  
**6445 SW 8TH STREET**  
**MIAMI FL 33144**

**Mailing Address**  
**6445 SW 8TH STREET**  
**MIAMI FL 33144**

**2. Principal Place of Business**

**3. Mailing Address**

**PO Box 511157**

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State  
**Punta Gorda, FL**

Zip

Country

Zip  
**33951**

Country

**USA**

**4. FEI Number 65-0323336**

Applied For

Not Applicable

**5. Certificate of Status Desired**

☐

**\$8.75 Additional Fee Required**

☒ CHECK HERE IF MAKING CHANGES

**6. Name and Address of Current Registered Agent**

**7. Name and Address of New Registered Agent**

**VALLADARES, JEANNETTE**  
**6445 S.W. 8TH STREET**  
**MIAMI FL 33144**

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. 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 \$550.00**

**After September 10, 2003 Fee will be \$750.00**

**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**

**11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11**

**TITLE**  
**PS**  
**VALLADARES, JEANNETTE**  
**6445 S.W. 8 STREET**  
**MIAMI FL**

☐ Delete

**TITLE**  
**NAME**  
**STREET ADDRESS**  
**CITY-ST-ZIP**

☐ Change ☐ Addition

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☐ 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**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (4/03)

Attachment#  
80140802  
V27348

**SOUTH MEDICAL PROFESSIONAL GROUP, INC.**

PO BOX 511157  
PUNTA GORDA, FL. 33951  
941-628-3590

**AUGUST 18, 2003**

**TO WHOM IT MAY CONCERN:**

**PLEASE WAIVE OUR LATE FEE SINCE THIS IS THE FIRST NOTICE WE RECEIVED FOR SOUTH MEDICAL PROFESSIONAL GROUP, INC. (DOC.# V27348). WE CHANGED OUR MAILING ADDRESS, BUT APPARENTLY IT WAS NOT REGISTERED.**

**ALSO, PLEASE SEND ME ANY ADDITIONAL FORMS I NEED TO CHANGE MY ADDRESS CORRECTLY.**

**THANK YOU VERY MUCH,**

  
**JEANNETTE VALLADARES**