# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**
**May 24, 2000 8:00 am**
**Secretary of State**
05-24-2000 90075 043 ****61.25

DOCUMENT # N99000002090

1. Entity Name

BIO-MECHANICAL RESEARCH & INTEGRATED HEALTH FOUN

| Principal Place of Business | Mailing Address |
|---|---|
| C/O DR. MANI DAS. D.V.M.<br>MICANOPY ANIMAL HOSPITAL. RT. 2<br>MICANOPY FL 32667 | C/O DR. MANI DAS. D.V.M.<br>MICANOPY ANIMAL HOSPITAL. RT. 2<br>MICANOPY FL 32667 |

DO NOT WRITE IN THIS SPACE

| 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 — ☑ 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 |
|---|---|
| LAPOLLA, MARY CAMPILII DC, DR.<br>C/O DR. MANI DAS, D.V.M.<br>MICANOPY ANIMAL HOSPITAL, RT. 2<br>MICANOPY FL 32667 | Name DR. HIMANI DAS, D.V.M<br>Street Address (P.O. Box Number is Not Acceptable) MICANOPY ANIMAL HOSPITAL<br>306 NE HWY 441<br>City MICANOPY FL Zip Code 32667 |

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

**FILE NOW: FEE IS $61.25**

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

**Make Check Payable to Department of State**

| 10. OFFICERS AND DIRECTORS | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10 | | |
|---|---|---|---|---|---|
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | D<br>LAPOLLA, MARY CAMPILII DR<br>740 LAIINTOWN ROAD<br>MILTON NY 12547 | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | D<br>DAS, MANI DR<br>MICANOPY ANIMAL HOSPITAL, RT. 2<br>MICANOPY FL 32667 | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | DAS, MANI D.V.M.<br>MICANOPY ANIMAL HOSPITAL<br>306 NE HWY 441 MICANOPY FL 32667 | ☒ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | D<br>LORD, PETER F<br>ULSTER SCIENTIFIC CORP.<br>NEW PALZ NY 12561 | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |
| TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Delete | TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP | | ☐ Change ☐ Addition |

CR2E137 (9/99)

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 617, 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:** Mary Campilii LaPolla, D.C. MARY C. LaPolla 4/31/2000 (914) 795-5150
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #