

**2008 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 13, 2008 08:00 AM
Secretary of State

DOCUMENT # P93000064114

1. Entity Name
HEALTH INFORMATION INC.



Principal Place of Business
**10185 COLLINS AVE
418
BAL HARBOUR, FL 33154**

Mailing Address
**10185 COLLINS AVE
418
BAL HARBOUR, FL 33154**



02072008 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
65-0456814

Applied For
Not Applicable

5. Certificate of Status Desired ☐ **\$8.75 Additional
Fee Required**

6. Name and Address of Current Registered Agent

**KATZ, SHMUEL E MD
10185 COLLINS AVE
418
BAL HARBOUR, FL 33154**

**DO NOT WRITE
IN THIS SPACE**

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 \$150.00
After May 1, 2008 Fee will be \$550.00**

9. Election Campaign Financing
Trust Fund Contribution. ☐

**\$5.00 May Be
Added to Fees**

10. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
**MD
KATZ, SHMUEL E MD
10185 COLLINS AVE
BAL HARBOUR, FL 33154**

TITLE
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STREET ADDRESS
CITY-ST-ZIP

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02/21/08-80015-015 150.00

**DO NOT WRITE
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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: *Shmuel Katz MD* **Shmuel Katz MD**

2.11.08

305 864 7770

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #