


FILE NOW: FILING FEE IS \$61.25

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Feb 24, 1999 8:00 am
Secretary of State

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NONPROFIT CORPORATION ANNUAL REPORT 1999				FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS	
DOCUMENT # 702018					
1. Corporation Name VISITING NURSE ASSOCIATION OF MIAMI-DADE, INC.					
Principal Place of Business 7715 NW 48TH STREET SUITE 200 MIAMI FL 33166 US			Mailing Address 7715 NW 48TH STREET SUITE 200 MIAMI FL 33166 US		



2. Principal Place of Business		2a. Mailing Address		3. Date Incorporated or Qualified	
21 Suite, Apt. #, etc.		26 Suite, Apt. #, etc.		02/13/1961	
22 City & State		27 City & State		4. FEI Number	
23 Zip		28 Zip		59-0654591	
24 Country		29 Country		30 Country	
5. Certificate of Status Desired <input checked="" type="checkbox"/>				Applied For	
				Not Applicable	
				\$8.75 Additional Fee Required	
6. Election Campaign Financing				\$5.00 May Be Added to Fees.	
Trust Fund Contribution <input type="checkbox"/>					

9. Name and Address of Current Registered Agent				10. Name and Address of New Registered Agent			
FUENTES, GUS, JR. 8900 N.W. 79TH AVE SUITE 720 MIAMI FL 33166				7715 NW 48th Street Suite 200 Miami, FL 33166			
81 Name				82 Street Address (P.O. Box Number is Not Acceptable)			
83				84 City			
				FL 85 Zip Code			

11. Pursuant to the provisions of Sections 617.0502 and 617.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 617.0503, Florida Statutes.

SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

12. OFFICERS AND DIRECTORS				13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12			
TITLE CD <input type="checkbox"/> DELETE NAME HUTSON, JAMES J STREET ADDRESS 1650 NW 9TH ST CITY-ST-ZIP MIAMI FL				1.1 TITLE <input type="checkbox"/> Change <input type="checkbox"/> Addition 1.2 NAME 1.3 STREET ADDRESS 1.4 CITY-ST-ZIP			
TITLE VD SD <input type="checkbox"/> DELETE NAME GIBSON, THELMA STREET ADDRESS 3661 FRANKLIN AVENUE CITY-ST-ZIP COCONUT FL				2.1 TITLE <input type="checkbox"/> Change <input type="checkbox"/> Addition 2.2 NAME 2.3 STREET ADDRESS 2.4 CITY-ST-ZIP			
TITLE SD <input checked="" type="checkbox"/> DELETE NAME ROBERTS, ALAN K STREET ADDRESS 8941 SUNSET DR, SUNSHINE MED CTR CITY-ST-ZIP MIAMI FL				3.1 TITLE VD <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition 3.2 NAME OMS, ERNEST E. 3.3 STREET ADDRESS 9601 S.W. 119 COURT 3.4 CITY-ST-ZIP MIAMI, FL 33186			
TITLE TED <input type="checkbox"/> DELETE NAME BOUE, LUIS E STREET ADDRESS 3001 PONCE DE LEON BLVD., SUITE 211 CITY-ST-ZIP CORAL GABLES FL 33134				4.1 TITLE <input type="checkbox"/> Change <input type="checkbox"/> Addition 4.2 NAME 4.3 STREET ADDRESS 4.4 CITY-ST-ZIP			
TITLE D <input checked="" type="checkbox"/> DELETE NAME CEJAS, ONELIO STREET ADDRESS 1325 W 48TH STREET - TRANSATLANTIC BANK CITY-ST-ZIP HALEAH FL 33012				5.1 TITLE D <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition 5.2 NAME MOSS, GLADYS 5.3 STREET ADDRESS 4100 N.W. 11TH AVENUE 5.4 CITY-ST-ZIP MIAMI, FL 33127			
TITLE D <input type="checkbox"/> DELETE NAME GIL, FRANCIS R STREET ADDRESS 20801 BISCAYNE BLVD., SUITE 400 CITY-ST-ZIP MIAMI FL 33180				6.1 TITLE D <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition 6.2 NAME SOSA, SUSANA 6.3 STREET ADDRESS JACKSON MEMORIAL HOSPITAL 1611 NW 12 AVE. 6.4 CITY-ST-ZIP MIAMI, FL 33136			

14. 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: _____

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/5/98

(305) 477-7676

Date

Daytime Phone #

CR2E037 (11/98)