

F11000001387

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

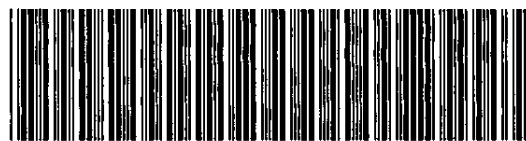
(Business Entity Name)

(Document Number)

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DIVISION OF CORPORATIONS  
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**COVER LETTER**

**TO:** Amendment Section  
Division of Corporations

**SUBJECT:** MAXXON HOME HEALTH CARE, INC.

Name of Corporation

**DOCUMENT NUMBER:** F11000001387

The enclosed Statement of Change of Registered Office/Agent and fee are submitted for filing.

Please return all correspondence concerning this matter to the following:

**WARREN K. TROWBRIDGE**

Name of Contact Person

**MAXXON HOME HEALTH CARE, INC.**

Firm/Company

**2646 SW MAPP RD, SUITE 206**

Address

**PALM CITY, FL 34990**

City/State and Zip Code

**ktbridge@aol.com**

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

**MARY JO F. THIBOULT**

Name of Contact Person

at **(772) 834-9496**

Area Code & Daytime Telephone Number

Enclosed is a \$35.00 check made payable to the Department of State.

**Mailing Address:**

Amendment Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

**Street Address:**

Amendment Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

**STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT OR  
BOTH FOR CORPORATIONS**

*Pursuant to the provisions of sections 607.0502, 617.0502, 607.1508, or 617.1508, Florida Statutes, this statement of change is submitted for a corporation organized under the laws of the State of Florida in order to change its registered office or registered agent, or both, in the State of Florida.*

1. The name of the corporation: MAXXON HOME HEALTH CARE, INC.  
2. The principal office address: 2646 SW MAPP RD, SUITE 206  
PALM CITY, FL 34990  
3. The mailing address (if different): SAME

4. Date of incorporation/qualification: 03/29/11 Document number: F11000001387

5. The name and street address of the current registered agent and registered office on file with the Florida Department of State: (If resigned, enter resigned)

WARREN K. TROWBRIDGE

2646 SW MAPP RD, SUITE 303

PALM CITY, FL 34990

6. The name and street address of the new registered agent (if changed) and /or registered office (if changed):

WARREN K. TROWBRIDGE

2646 SW MAPP RD, SUITE 206

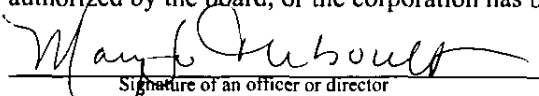
P.O. Box NOT acceptable

PALM CITY, FL 34990

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The street address of its registered office and the street address of the business office of its registered agent, as changed will be identical.

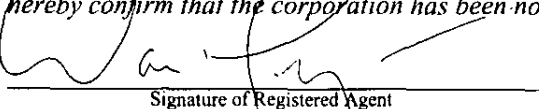
Such change was authorized by resolution duly adopted by its board of directors or by an officer so authorized by the board, or the corporation has been notified in writing of the change.

  
Signature of an officer or director

MARY JO F. THIBOULT

Printed or typed name and title

*I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligation of my position as registered agent. Or, if this document is being filed merely to reflect a change in the registered office address, I hereby confirm that the corporation has been notified in writing of this change.*

  
Signature of Registered Agent

WARREN K. TROWBRIDGE

Date

If signing on behalf of an entity:

MAXXON HOME HEALTH CARE, INC.

Typed or Printed Name

\*\*\* FILING FEE: \$35.00 \*\*\*

MAKE CHECKS PAYABLE TO FLORIDA DEPARTMENT OF STATE  
MAIL TO: DIVISION OF CORPORATIONS, P.O. BOX 6327, TALLAHASSEE, FL 32314