

2004 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Apr 21, 2004 8:00 am
Secretary of State

04-21-2004 90065 048 ***150.00

DOCUMENT # K83191

1. Entity Name

ALPHA ORTHO-CARE, INC.



Principal Place of Business

1401 E 4TH AVE
STE 104
HIALEA FL 33010
US

Mailing Address

1401 E 4TH AVE
STE 104
HIALEA FL 33010
US

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country



MOORE

CR2E034 (11/03)

4. FEI Number
65-0117590

Applied For
Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

QUIRANTES, TULIO
1401 E 4TH AVE
STE 102
HIALEAH FL 33010

7. Name and Address of New Registered Agent

Name **BOLUFER, FERNANDO A., M.D.**
Street Address (P.O. Box Number is Not Acceptable)
1401 E 4TH AVE
SUITE 104
City **HIALEAH** FL **33010**

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, 2004 Fee will be \$550.00
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

TITLE	PTSD	<input type="checkbox"/> Delete
NAME	QUIRANTES, TULIO	
STREET ADDRESS	1401 E 4TH AVE STE 102	
CITY-ST-ZIP	HIALEAH FL 33016	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE		<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	BOLUFER, FERNANDO A., M.D.	
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

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:

Fernando Bolufer - Fernando Bolufer M.D. 04/20/04 (305) 888-9200
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #