LIMITED LIABILITY COMPANY

UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # 202. L.L.C. A/R

FILED
Jul 02, 2002 8:00 am
Secretary of State
07-02-2002 90817 015 ****50.00

1. Entity Name

HEALTHSTYLERS LLC
L01000010047

DO NOT WRITE IN THIS SPACE

969656

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	3. Mailing Address
3507 S.E. Ft. King St.	
Suite, Apt. #, etc. 234	Suite, Apt. #, etc.
City & State Ocala, Florida	City & State
Zip 34470 Country USA	Zip Country

4. FEI Number 59-3730824 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $5.00 Additional Fee Required

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7. Name and Address of Current Registered Agent

Name Liliana Estes

Street Address (P.O. Box Number is Not Acceptable) 3507 S.E. Ft. King St.

City Ocala FL Zip Code 34470

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 ______________________ DATE
Signature, typed or printed name of registered agent and title if applicable.

FEE IS $50.00
Make Check Payable to Department of State
DUE BY MAY 1

9. MANAGING MEMBERS/MANAGERS

TITLE	MGRM
NAME	Liliana Estes
STREET ADDRESS	3507 SE FT KING ST
CITY-ST-ZIP	Ocala, FL. 34470
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
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TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

DO NOT WRITE IN THIS SPACE

11. 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 is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE: [signature] 6.25.02
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE Date Daytime Phone #