

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # **L32915**
 1. Entity Name **The BALANCE DISORDERS CLINIC, Inc**

FILED
 00 JUL 21 AM 10:27
 SECRETARY OF STATE
 TALLAHASSEE, FLORIDA

Principal Place of Business Mailing Address
1401. CENTERVILLE Rd. **P.O. Box 13393**
Suite 510 **Jal, Fl 32317**
Jal, Fl. 32308 US.

2. Principal Place of Business 3. Mailing Address
Same as above **Same as above**
 Suite, Apt. #, etc. Suite, Apt. #, etc.
 City & State City & State
 Zip Country Zip Country

REINSTATEMENT 09-00

4. FEI Number **59-2984100** Applied For Not Applicable
 5. Certificate of Status Desired **\$8.75 Additional Fee Required**

6. Name and Address of Current Registered Agent
Maillard, Charles G
4935 Arden Forest Way
Jal, Fl. 32308

7. Name and Address of New Registered Agent
 Name _____
 Street Address (P.O. Box Number is Not Acceptable) _____
 City **FL** Zip Code _____

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  **President Charles G Maillard 4/26/00**
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so.
(See criteria on back)

FILE NOW!!! FEE IS \$150.00
After MAY 1, 2000 Fee will be \$550.00
Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. **\$5.00** May Be Added to Fees

11. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
President Charles G. Maillard 4935 Arden Forest Way Jal, Fl. 32308	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
800003349548--4 -08/08/00--01078--007 ****300.00 ****300.00	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

13. 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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE  **CC/VA/ITC/BWD 4/26/00 850 878-3592**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (9/99)