

Caribe Medical Center  
24 N.W. 29th STREET  
MIAMI, FLORIDA 33127

City/State/Zip

Phone #

Office Use Only

CORPORATION NAME(S) & DOCUMENT NUMBER(S), (if known):

1. M 53356  
(Corporation Name) (Document #)
2. \_\_\_\_\_  
(Corporation Name) (Document #)
3. \_\_\_\_\_  
(Corporation Name) (Document #)
4. \_\_\_\_\_  
(Corporation Name) (Document #)

☐ Walk in

☐ Pick up time \_\_\_\_\_

☐ Certified Copy

☐ Mail out

☐ Will wait

☐ Photocopy

☐ Certificate of Status

| NEW FILINGS              |                   |
|--------------------------|-------------------|
| <input type="checkbox"/> | Profit            |
| <input type="checkbox"/> | NonProfit         |
| <input type="checkbox"/> | Limited Liability |
| <input type="checkbox"/> | Domestication     |
| <input type="checkbox"/> | Other             |

| AMENDMENTS               |  |
|--------------------------|--|
| <input type="checkbox"/> | Amendment                              |
| <input type="checkbox"/> | Resignation of R.A., Officer/ Director |
| <input type="checkbox"/> | Change of Registered Agent             |
| <input type="checkbox"/> | Dissolution/Withdrawal                 |
| <input type="checkbox"/> | Merger                                 |

| OTHER FILINGS            |                  |
|--------------------------|------------------|
| <input type="checkbox"/> | Annual Report    |
| <input type="checkbox"/> | Fictitious Name  |
| <input type="checkbox"/> | Name Reservation |

| REGISTRATION/<br>QUALIFICATION |                     |
|--------------------------------|---------------------|
| <input type="checkbox"/>       | Foreign             |
| <input type="checkbox"/>       | Limited Partnership |
| <input type="checkbox"/>       | Reinstatement       |
| <input type="checkbox"/>       | Trademark           |
| <input type="checkbox"/>       | Other               |

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-09/25/97--01032--011  
\*\*\*\*\*35.00 \*\*\*\*\*35.00

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SECRETARY OF STATE  
DIVISION OF CORPORATIONS  
97 SEP 25 PM 1:49



Florida Department of State, Jim Smith, Secretary of State...

**RESIGNATION OF OFFICER AND/OR DIRECTOR**

**AFFIDAVIT**

STATE OF Florida:  
COUNTY OF Dade:

I MARIA L. Cheverez after being duly sworn, state that to the best of my knowledge, information and belief, and under penalties of perjury, the following is true and correct:

1. I MARIA L. Cheverez hereby resign as President of  
(Title)  
CARIBE Medical Center, Inc, a Florida corporation;  
(Name of Corporation)

2. That the corporation has been notified in writing of the resignation; and
3. That corporate minutes relating to the resignation are unavailable.

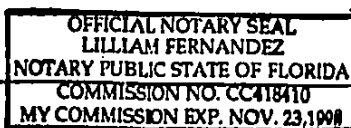
FURTHER AFFIANT SAYETH NOT.

Maria L. Cheverez

AFFIANT

Sworn to and subscribed before me this 18th day of September, 1997

Lilliam Fernandez



NOTARY PUBLIC

My Commission Expires:

\$35.00

FILING FEE IS \$20.00

DIVISION OF CORPORATIONS, P.O. BOX 6327, TALLAHASSEE, FL 32314

(904) 487-6051

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