N17000000045

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

APR 05 2018
T. LEMIEUX

COVER LETTER

TO: Amendment Section
Division of Corporations

SUBJECT: SUNCOAST RECOVERY CENTER INC
Name of Corporation

DOCUMENT NUMBER: N17000000045

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:

THOMAS SAXON
Name of Contact Person

SUNCOAST RECOVERY
Firm/Company

8453 CRANES ROOST DR
Address

NEW PORT RICHEY, FL 34654
City/State and Zip Code

tomsaxon350yahoo.com
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

THOMAS SAXON at (727) 255-9683
Name of Contact Person 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 _____ _____ in order to change its registered office or registered agent, or both, in the State of Florida.

1. The name of the corporation: SUNCOAST RECOVERY CENTER INC

2. The principal office address: 5341 GRAND Blvd., Suite 110A, NEW PORT RICHEY, FL 34652

3. The mailing address (if different): _____

4. Date of incorporation/qualification: 01/03/2017 Document number: N17000000045

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)

DAVID SAXON
7 PREMIER COURT
NESCONSET, NY 11767

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

ALFONZO RUIZ, M.D.
4345 HARBORPOINTE DR. PORT RICHEY, FL. 34668
P.O. Box NOT acceptable

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

THOMAS V. SAXON
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

2/27/2018
Date

If signing on behalf of an entity:

ALFONZO RUIZ, M.D
Typed or Printed Name

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

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

CR2E045 (03/12)