

**2005 NOT-FOR-PROFIT CORPORATION
ANNUAL REPORT**

FILED

**Feb 02, 2005 08:00 AM
Secretary of State**

DOCUMENT # N42078

1. Entity Name
WEE CARE, WILDLIFE REHABILITATION CENTER, INC.



Principal Place of Business
**15390 SW 269 TERR
HOMESTEAD, FL 33032 US**

Mailing Address
**15390 SW 269 TERR
HOMESTEAD, FL 33032 US**



01052005 No Chg-NP CR2E037 (10/03)

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4. FEI Number
65-0251360

Applied For
Not Applicable

5. Certificate of Status Desired ☒ **\$8.75 Additional
Fee Required**

6. Name and Address of Current Registered Agent

**KNOX, PAT
15390 SW 269 TERR
HOMESTEAD, FL 33032**

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IN THIS SPACE**

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 re-filing) DATE _____

**Filing Fee is \$61.25
Due by May 1, 2005**

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

10. OFFICERS AND DIRECTORS

TITLE	DPS
NAME	KNOX, PAT
STREET ADDRESS	15390 SW 269 TERR
CITY-STATE-ZIP	HOMESTEAD, FL
TITLE	VP
NAME	KNOX, THOMAS
STREET ADDRESS	15390 SW 269 TERR
CITY-STATE-ZIP	HOMESTEAD, FL
TITLE	D
NAME	PETR, PROY
STREET ADDRESS	20732 SW 80 CT
CITY-STATE-ZIP	MIAMI, FL 33189
TITLE	D
NAME	WORTH, ALLISON
STREET ADDRESS	19778 SW 243 TERRACE
CITY-STATE-ZIP	MIAMI, FL 33031
TITLE	
NAME	
STREET ADDRESS	
CITY-STATE-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-STATE-ZIP	

1100000210890
02/02/05-80100-003 70.00

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IN THIS SPACE**

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 817, 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: *Pat Knox*
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

2-1-05 (305) 248-0947
Date Daytime Phone #