

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Jun 24, 2002 8:00 am
Secretary of State

05-10-2002 90063 002 ***150.00

DOCUMENT # P00000025504

1. Entity Name

SILICON BEACH FUNDING CORP.

Principal Place of Business

**1901 JOHNSON ST #1
HOLLYWOOD FL 33020**

Mailing Address

**1901 JOHNSON ST #1
HOLLYWOOD FL 33020**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

DO NOT WRITE IN THIS SPACE

4. FEI Number

APPLIED FOR☒ Applied For☐ Not Applicable5. Certificate of Status Desired ☐**\$8.75 Additional
Fee Required**

6. Name and Address of Current Registered Agent

MASTERS, M.S.**1901 JOHNSON ST #1
HOLLYWOOD FL 33020**

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

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, 2002 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	PD MASTERS, L.V. 1901 JOHNSON ST #1 HOLLYWOOD FL 33020	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	SD MASTERS, M.S. 1901 JOHNSON ST #1 HOLLYWOOD FL 33020	<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
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
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
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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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4/24/02 (94)
 Date Daytime Phone #

CR2E034 (9/01)

Attachment# 36689
PO0000025504

TRANSMISSION VERIFICATION REPORT

TIME : 06/13/2002 15:46
NAME : ADAGEN MEDICAL CNSLT
FAX : 9544566528
TEL : 9544565199

DATE, TIME
FAX NO. /NAME
DURATION
PAGE(S)
RESULT
MODE

06/13 15:46
16314478960
00:00:37
01
OK
STANDARD
ECM

Attn: EIN Operation 631-447-8960

Form SS-4 (Rev. December 2001) Department of the Treasury Internal Revenue Service	Application for Employer Identification Number (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ See separate instructions for each line. ▶ Keep a copy for your records.	EIN OMB No. 1545-0003
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Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested SILICON BEACH FUNDING CORP	3 Executor, trustee, "care of" name M.S. MASTERS
	2 Trade name of business (if different from name on line 1)	
	4a Mailing address (room, apt., suite no. and street, or P.O. box) 1901 JOHNSON ST #1	5a Street address (if different) (Do not enter a P.O. box.)
	4b City, state, and ZIP code HOLLYWOOD FL 33020	5b City, state, and ZIP code
	6 County and state where principal business is located BROWARD FLA	
	7a Name of principal officer, general partner, grantor, owner, or trustor M.S. MASTERS	7b SSN, ITIN, or EIN 462-92-2961

8a Type of entity (check only one box)	<input type="checkbox"/> Estate (SSN of decedent)
<input type="checkbox"/> Sole proprietor (SSN)	<input type="checkbox"/> Plan administrator (SSN)
<input type="checkbox"/> Partnership	<input type="checkbox"/> Trust (SSN of grantor)
<input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶	<input type="checkbox"/> National Guard <input type="checkbox"/> State/local government
<input type="checkbox"/> Personal service corp.	<input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military
<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises
<input type="checkbox"/> Other nonprofit organization (specify) ▶	Group Exemption Number (GEN) ▶
<input type="checkbox"/> Other (specify) ▶	

8b If a corporation, name the state or foreign country (if applicable) where incorporated FLORIDA	State FLORIDA	Foreign country
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9 Reason for applying (check only one box)	<input type="checkbox"/> Banking purpose (specify purpose) ▶
<input checked="" type="checkbox"/> Started new business (specify type) ▶ CONSULTING	<input type="checkbox"/> Changed type of organization (specify new type) ▶
<input type="checkbox"/> Hired employees (Check the box and see line 12.)	<input type="checkbox"/> Purchased going business
<input type="checkbox"/> Compliance with IRS withholding regulations	<input type="checkbox"/> Created a trust (specify type) ▶
<input type="checkbox"/> Other (specify) ▶	<input type="checkbox"/> Created a pension plan (specify type) ▶

10 Date business started or acquired (month, day, year) JUNE 2002	11 Closing month of accounting year DEC 2002
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12 First date wages or annuities were paid or will be paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)

13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter "-0-."	Agricultural	Household	Other
	0	0	0

14 Check one box that best describes the principal activity of your business.	<input type="checkbox"/> Health care & social assistance	<input type="checkbox"/> Wholesale-agent/broker
<input type="checkbox"/> Construction	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale-gther
<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Other (specify) CONSULTING	<input type="checkbox"/> Retail
<input type="checkbox"/> Transportation & warehousing		
<input type="checkbox"/> Real estate		
<input type="checkbox"/> Manufacturing		
<input type="checkbox"/> Finance & insurance		

Attn: EIN Operation 631-447-8960 Attachment #3 6689
P00000025504

Form **SS-4**

(Rev. December 2001)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ See separate instructions for each line. ▶ Keep a copy for your records.

EIN

OMB No. 1545-0003

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested SILICON BEACH FUNDING CORP		
	2 Trade name of business (if different from name on line 1)		3 Executor, trustee, "care of" name M.S. MASTERS
	4a Mailing address (room, apt., suite no. and street, or P.O. box) 1901 JOHNSON ST #1		5a Street address (if different) (Do not enter a P.O. box.)
	4b City, state, and ZIP code HOLLYWOOD FL 33020		5b City, state, and ZIP code
	6 County and state where principal business is located BROWARD FLA		
	7a Name of principal officer, general partner, grantor, owner, or trustor M.S. MASTERS		7b SSN, ITIN, or EIN 462-92-2961
8a Type of entity (check only one box) <input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ _____ <input type="checkbox"/> Personal service corp. <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input type="checkbox"/> Other (specify) ▶ _____ <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Plan administrator (SSN) _____ <input type="checkbox"/> Trust (SSN of grantor) _____ <input type="checkbox"/> National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises Group Exemption Number (GEN) ▶ _____			
8b If a corporation, name the state or foreign country (if applicable) where incorporated State FLORIDA Foreign country _____			
9 Reason for applying (check only one box) <input checked="" type="checkbox"/> Started new business (specify type) ▶ CONSULTING <input type="checkbox"/> Hired employees (Check the box and see line 12.) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) ▶ _____ <input type="checkbox"/> Banking purpose (specify purpose) ▶ _____ <input type="checkbox"/> Changed type of organization (specify new type) ▶ _____ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> Created a pension plan (specify type) ▶ _____			
10 Date business started or acquired (month, day, year) JUNE 2002		11 Closing month of accounting year DEC 2002	
12 First date wages or annuities were paid or will be paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year) ▶			
13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter "-0-". ▶			
14 Check one box that best describes the principal activity of your business. <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input checked="" type="checkbox"/> Other (specify) CONSULTING <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker			
15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. MEDICAL CONSULTING SVC.			
16a Has the applicant ever applied for an employer identification number for this or any other business? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Note: If "Yes," please complete lines 16b and 16c.			
16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above. Legal name ▶ _____ Trade name ▶ _____			
16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (mo., day, year) _____ City and state where filed _____ Previous EIN _____			
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.		
	Designee's name Address and ZIP code		Designee's telephone number (include area code) () Designee's fax number (include area code) ()
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.			
Name and title (type or print clearly) ▶ M.S. MASTERS, Agent of Record		Applicant's telephone number (include area code) (954) 579 0292	
Signature ▶ M.S. MASTERS		Applicant's fax number (include area code) (954) 456- 5199	