FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)

1 of 2

DOCUMENT # P00000024699

1. Entity Name

CALL THE DOCTOR HEALTH CARE INC

FILED

02 SEP 18 PM 4:15

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	3. Mailing Address
P.O. BOX: 557246	P.O. BOX: 557246
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: MIAMI	City & State: MIAMI
Zip: FL 33255 Country: USA.	Zip: FL 33255 Country: USA

DO NOT WRITE IN THIS SPACE 05/23/02 90023 003 $150.00

4. FEI Number: 65-0991560 ☐ Applied For ☐ Not Applicable

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

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7. **Name and Address of Current Registered Agent**

Name: MIGUEL A. ARANGO

Street Address (P.O. Box Number is Not Acceptable)

564 SW. LeJeune Rd.

City: MIAMI FL Zip Code: 33134

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 _____ DATE

Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

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

January 1 - May 1 Fee is $150.00
After May 1, Fee is $550.00
Amended UBR is $61.25
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	President
NAME	MIGUEL A. ARANGO
STREET ADDRESS	564 SW. LeJeune Rd.
CITY-ST-ZIP	Miami FL. 33134

DO NOT WRITE IN THIS SPACE

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 on an attachment with an address, with all other like empowered.

SIGNATURE: _____

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

2852

CALL THE DOCTOR HEALTH CARE INC.
P.O. BOX 9400006
MIAMI, FL 33184

Ref: P00000027699
Call The Doctor Health Care Inc.
Att: Tyrome

Per our conversation on September 11, 2002, that I had sent my annual report on time with a money order, I wondered why I had never received it, and I called your office and they explained that it was rejected do to the Id number was missing. As I explained that I never received any reject letter from the state regarding this matter. Please excuse my delay and thank you for waiving the fee.

Thanking you in advance,

Miguel A. Bravo

UNITED STATES POSTAL SERVICE

CUSTOMER'S RECEIPT

KEEP THIS RECEIPT FOR YOUR RECORDS

PAY TO: Department of State
ADDRESS: Call the Doctor Healthcare Inc
C.O.D. OR USED FOR:

SEE BACK OF THIS RECEIPT FOR IMPORTANT CLAIM INFORMATION

NOT NEGOTIABLE

SERIAL NUMBER	YEAR, MONTH, DAY	POST OFFICE	AMOUNT	CLERK
03819527357	2002-04-30	331740	$ 150.00	0005