

2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 27, 2007 08:00 A
Secretary of State

DOCUMENT # P00000053940

1. Entity Name
OREX MEDICAL CENTER CORPORATION



Principal Place of Business
**4980 WEST 10TH AVE., SUITE 205
HIALEAH, FL 33012**

Mailing Address
**4980 WEST 10TH AVE., SUITE 205
HIALEAH, FL 33012**

DO NOT WRITE IN THIS SPACE



04192007 No Chg-P CR2E034 (11/05)

4. FEI Number
65-1018011

Applied For
Not Applicable

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

6. Name and Address of Current Registered Agent

**FERNANDEZ, MANUEL F
8420 WEST FLAGER
SUITE 220
MIAMI, FL 33144**

**DO NOT WRITE
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 reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00
After May 1, 2007 Fee will be \$550.00**

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**PSTD
FERNANDEZ, MANUEL F
4980 WEST 10TH AVE., SUITE 205
HIALEAH, FL 33012**

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

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U00000735714
05/10/07-80045-002 150.00

**DO NOT WRITE
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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 10 or Block 11 if changed, or on an attachment with an address, with all other like information.

SIGNATURE: *[Signature]*

MANUEL F. FERNANDEZ, M.D., P.A.

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

04-23-07 (305) 556-4205