2002 UNIFORM BUSINESS REPORT (UBR)

FILED
May 01, 2002 8:00 am
Secretary of State
05-01-2002 91598 038 ***150.00

DOCUMENT # P01000006689

1. Entity Name
GOLANSKI MEDICAL SERVICES, INC.

Principal Place of Business	Mailing Address
8420 WEST FLAGLER STREET SUITE 220 MIAMI FL 33144	8420 WEST FLAGLER STREET SUITE 220 MIAMI FL 33144

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 SEE FR Attached ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent	7. Name and Address of New Registered Agent
FERNANDEZ, MANUEL F M.D. 8420 WEST FLAGLER STREET SUITE 220 MIAMI FL 33144	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		12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PTSD FERNANDEZ, MANUEL F M.D. 8420 WEST FLAGLER STREET MIAMI FL 33144 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition

CR2E034 (9/01)

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] PRES. 4/17/02 305-207-1818
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

ATTACHMENT
BOO83111

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
GOLANDSKI MEDICAL SERVICES, INC.

2 Trade name of business (if different from name on line 1)

3 Executor, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
8420 WEST FLAGLER STREET, SUITE 220

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code
MIAMI, FLORIDA 33144

5b City, state, and ZIP code

6 County and state where principal business is located
MIAMI-DADE, FLORIDA

P01000006689

7a Name of principal officer, general partner, grantor, owner, or trustor
MANUEL M. FERNANDEZ, M.D.

7b SSN, ITIN, or EIN
594-17-2003

8a Type of entity (check only one box)

- ☐ Sole proprietor (SSN) _____
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶ _____
- ☐ Personal service corp.
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶ _____
- ☑ Other (specify) ▶ **CORPORATION**
- ☐ Estate (SSN of decedent) _____
- ☐ Plan administrator (SSN) _____
- ☐ Trust (SSN of grantor) _____
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ 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)

- ☑ Started new business (specify type) ▶ **MEDICAL SERVICES**
- ☐ Hired employees (Check the box and see line 12.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ Banking purpose (specify purpose) ▶ _____
- ☐ Changed type of organization (specify new type) ▶ _____
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶ _____
- ☐ Created a pension plan (specify type) ▶ _____

10 Date business started or acquired (month, day, year)
3-1-02

11 Closing month of accounting year
DECEMBER

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:

14 Check one box that best describes the principal activity of your business.

- ☑ Health care & social assistance
- ☐ Wholesale–agent/broker
- ☐ Construction
- ☐ Rental & leasing
- ☐ Transportation & warehousing
- ☐ Accommodation & food service
- ☐ Wholesale–other
- ☐ Retail
- ☐ Real estate
- ☐ Manufacturing
- ☐ Finance & insurance
- ☐ Other (specify)

15 Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided.
SERVICES PROVIDED

16a Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☑ 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: Gloria M. Batule, CPA
Address and ZIP code: 782 N. Le Jeune Road, Suite 447, Miami, FL 33126
Designee's telephone number (include area code): (305) 441-6464
Designee's fax number (include area code): (305) 447-9101

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) ▶ MANUEL F. FERNANDEZ, Pres.

Applicant's telephone number (include area code): (305) 207-1616

Signature ▶ _____ Date ▶ 10-10-02

Applicant's fax number (include area code): (305) 513-0185

MANUEL F. FERNANDEZ, M.D.

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 12-2001)