

**FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**

DOCUMENT # *P01060008842*

1. Entity Name

Acu Re Hab & med center

FILED

02 OCT 11 AM 10:31

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business

Acu Rehab & med center

3. Mailing Address

same as Box #2

Suite, Apt. #, etc.

4297 N. State RD 7

Suite, Apt. #, etc.

City & State

Lauderdale Lakes FL 33389

City & State

Zip

Country

Zip

Country

4. FEI Number

651078255

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

DO NOT WRITE IN THIS SPACE

**DO NOT WRITE
IN THIS SPACE**

7. Name and Address of Current Registered Agent

Name

Gregoire GARCON DPM

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

5297 N. State RD 7

Lauderdale Lake

City

FL

Zip Code

33319

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)

8/26/02

DATE

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
NAME
STREET ADDRESS
CITY-ST-ZIP
Dr Gregoire GARCON DPM
4297 N. State RD 7
Lauderdale Lakes FL 33319

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
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**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 #

CR2E034B (12/01)



Acu Rehab & Medical Center

4297 N. State Rd. 7
Lauderdale Lakes, FL 33319
Office: (954) 535-1919
Fax: (954) 535-1915

Please be aware that the form
are not with me, and I want
to send my check on time

Corp Name: Acu Rehab & med center,

101000008842



Acu Rehab & Medical Center

4297 N. State Rd. 7
Lauderdale Lakes, FL 33319
Office: (954) 535-1919
Fax: (954) 535-1915

During our phone conversation, you advised me to write down a few words, to let you know that this form was a return. You promised that you will waive any additional fees, because my check was mailed on time first time.

Thank you for your understanding

Dr. Hanson