

2005 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 25, 2005 08:00 AM
Secretary of State

DOCUMENT # P01000055179 1. Entity Name HAITI MEDICAL CLINIC, INC. P.A.			
Principal Place of Business 5000 NE 2ND AVE MIAMI, FL 33137		Mailing Address 5000 NE 2ND AVE MIAMI, FL 33137	
DO NOT WRITE IN THIS SPACE			
5. Name and Address of Current Registered Agent POLIARD, JOEL H MD 5000 NE 2ND AVE MIAMI, FL 33137		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.		DATE _____ (NOTE: Registered Agent signature required when signing)	
FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00		9. Election Campaign Financing Trust Fund Contribution. ☐ \$5.00 May Be Added to Fees	
10. OFFICERS AND DIRECTORS		DO NOT WRITE IN THIS SPACE	
TITLE NAME STREET ADDRESS CITY- ST- ZIP	PD POLIARD, JOEL H M.D. 5000 NE 2ND AVE MIAMI, FL 33137		
TITLE NAME STREET ADDRESS CITY- ST- ZIP	DO NOT WRITE IN THIS SPACE		
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12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(j), 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 empowered.			
SIGNATURE: _____ SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR		Date 4/22/05 Time 3:05-7:51-1/05 Daytime Phone #	