

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Jul 14, 2003 8:00 am
Secretary of State

07-14-2003 90325 031 ***150.00

DOCUMENT # P01000089593

1. Entity Name
A SPOONFUL OF HEALTH, INC.



Principal Place of Business
**3569 FOXCROFT CIRCLE
OVIEDO FL 32765**

Mailing Address
**3569 FOXCROFT CIRCLE
OVIEDO FL 32765**



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number **32-0003769**

Applied For
Not Applicable

Zip

Country

Zip

Country

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

**MALONE, J MICHAEL
523 W COLONIAL DRIVE
ORLANDO FL 32804**

Name **James J. Justison**

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

5349 Lake Jessamine Dr.

City **Orlando**

FL

Zip Code **32839**

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 **JAMES J. JUSTISON**

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

FILE NOW!!! FEE IS \$550.00

**After September 10, 2003 Fee will be \$750.00
Make Check Payable to Florida Department of State**

9. Election Campaign Financing Trust Fund Contribution. ☐ **\$5.00 May Be Added to Fees**

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **P** ☐ Delete
NAME **BERRY, EILEEN P**
STREET ADDRESS **3569 FOXCROFT CIRCLE**
CITY-ST-ZIP **OVIEDO FL 32765**

TITLE ☐ Change ☐ Addition
NAME
STREET ADDRESS
CITY-ST-ZIP

TITLE ☐ Delete
NAME
STREET ADDRESS
CITY-ST-ZIP

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CITY-ST-ZIP

12. 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE **BERNARD REQUIRED**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7/7/2003 (407) 718-9098

Date Daytime Phone #

CR2E034 (4/03)

Attachment 10109796
#P01000089593RE:FEI #:32-0003769

to whom I pay my premium
A SPONFUL OF HEALTH, INC.

The Gentleman who answered at
(850)245-6059, was kind enough to direct
me to (1) under "frequently asked questions."

I had explained, after he could not
locate my filing, that I had done so
by mail, several months ago. He told
me to send the \$150.00 as I had
originally. I stopped payment on the
original check, as it is obviously lost.

Thank you so much for your assistance.

Please Call if you have questions (407) 718-9098
(CELL).

John J. Perry
President
A Sponful of Health, Inc.