

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

DOCUMENT # P01000090741

1. Entity Name

HEALTH-ALLIANCE INJURY AND PAIN MANAGEMENT, INC.

FILED  
02 MAY 15 PM 2:56

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

**DO NOT WRITE IN THIS SPACE**

2. Principal Place of Business

2760 SW 97 AVE

Suite, Apt. #, etc.

SUITE 111 & 112

City & State

MIAMI, FL

Zip

33165

Country

USA

3. Mailing Address

2760 SW 97 AVE

Suite, Apt. #, etc.

SUITE 111 & 112

City & State

MIAMI, FL

Zip

33165

Country

USA

DO NOT WRITE IN THIS SPACE

4. FEI Number

☒ Applied For  
☐ Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional  
Fee Required

7. Name and Address of Current Registered Agent

Name RITA E. CRUZ

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

1187 NW 125TH COURT

City MIAMI

FL

Zip Code 33182

**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.

SIGNATURE

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

(NG) L. Registered Agent signature, required when renewing

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 \$350.00

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 RITA E. CRUZ (P/D)  
NAME  
STREET ADDRESS 1187 NW 125TH COURT  
CITY - ST - ZIP MIAMI, FL 33182

TITLE  
NAME  
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CITY - ST - ZIP

000005620550-13  
-05/28/02--01019--014  
\*\*\*\*150.00 \*\*\*\*150.00

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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)(f), 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

05/14/02.

DATE

Signature Phone #

282  
HEALTH-ALLIANCE INJURY AND PAIN MANAGEMENT, INC.  
DOC. # P01000090741

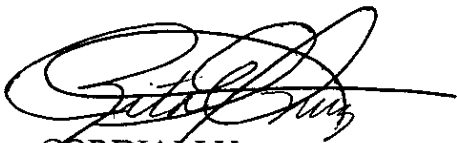
TO: DIVISION OF CORPORATION  
P.O. BOX 6327  
TALLAHASSEE, FL 32314

TO WHOM IT MAY CONCERN:

ENCLOSED YOU WILL FIND THE ANNUAL REPORT FORM ALONG WITH A  
CHECK PAYABLE TO THE FLORIDA DEPARTMENT OF STATE TO PROPERLY  
UP-DATE THE ABOVE MENTIONED CORPORATION.

DUE TO A CHANGE OF PRINCIPAL AND MAILING ADDRESS I NEVER  
RECEIVED FIRST NOR SECOND NOTICE OF SUCH REPORT. PLEASE TAKE  
THIS LETTER AS AN EXCUSE TO PUT THIS CORPORATION IN ITS CURRENT  
STATUS.

THANK YOU IN ADVANCE FOR YOUR PROMPT ATTENTION IN THIS MATTER  
AND IF YOU SHOULD HAVE ANY QUESTION REGARDING THIS LETTER  
DON'T HESITATE TO CONTACT ME AT THE NEW ADDRESS LISTED IN THE  
ANNUAL REPORT .



CORDIALLY  
RITA E. CRUZ  
PRESIDENT