


# 2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 17, 2003 8:00 am**  
**Secretary of State**

04-17-2003 90210 044 \*\*\*150.00

|   |   |     |  |   |  |
|---|---|-----|--|---|--|
| <b>DOCUMENT #</b> P02000081792  |   |     |  |                                |  |
| 1. Entity Name<br><b>UNITED CHIROPRACTIC CENTER OF FLORIDA, INC.</b>  |   |     |  |   |  |
| Principal Place of Business<br>6565 TAFT STREET<br>SUITE 404<br>HOLLYWOOD FL 33024  |   |     | Mailing Address<br>6565 TAFT STREET<br>SUITE 404<br>HOLLYWOOD FL 33024 |   |  |
| 2. Principal Place of Business  |   |     | 3. Mailing Address   |   |  |
| Suite, Apt., #, etc.  |   |     | Suite, Apt., #, etc.   |   |  |
| City & State  |   |     | City & State   |   |  |
| Zip   | Country   | Zip | Country  | 4. FEI Number<br><b>27-0026472</b>  |  |
|   |   |     |  | <input type="checkbox"/> CHECK HERE IF MAKING CHANGES<br>Applied For<br><input type="checkbox"/> Not Applicable |  |
| 5. Certificate of Status Desired <input type="checkbox"/>   |   |     |  | \$8.75 Additional Fee Required  |  |
| 6. Name and Address of Current Registered Agent   |   |     | 7. Name and Address of New Registered Agent                            |   |  |
| <b>MORSE, DANIELLE DR.</b><br><b>6565 TAFT STREET</b><br><b>SUITE 404</b><br><b>HOLLYWOOD FL 33024</b>  |   |     | 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. I am familiar with, and accept the obligations of registered agent.   |   |     |  |   |  |
| SIGNATURE <u><i>[Signature]</i></u> DATE _____<br><small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>   |   |     |  |   |  |
| <b>FILE NOW!!! FEE IS \$150.00</b><br><b>After May 1, 2003 Fee will be \$550.00</b><br><b>Make Check Payable to Florida Department of State</b>   |   |     |  |   |  |
| 10. OFFICERS AND DIRECTORS  |   |     | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11                  |   |  |
| TITLE   | D MORSE, DANIELLE DR <input checked="" type="checkbox"/> Delete |     | TITLE  | P NANCY TRANG <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition                      |  |
| NAME  | 6565 TAFT STREET, SUITE 404                                     |     | NAME   | 6565 TAFT ST  |  |
| STREET ADDRESS  | HOLLYWOOD FL 33024  |     | STREET ADDRESS   | HOLLYWOOD, FL 33024   |  |
| CITY- ST- ZIP   |   |     | CITY- ST- ZIP  |   |  |
| TITLE   | <input type="checkbox"/> Delete                                 |     | TITLE  | <input type="checkbox"/> Change <input type="checkbox"/> Addition   |  |
| NAME  |   |     | NAME   |   |  |
| STREET ADDRESS  |   |     | STREET ADDRESS   |   |  |
| CITY- ST- ZIP   |   |     | CITY- ST- ZIP  |   |  |
| TITLE   | <input type="checkbox"/> Delete                                 |     | TITLE  | <input type="checkbox"/> Change <input type="checkbox"/> Addition   |  |
| NAME  |   |     | NAME   |   |  |
| STREET ADDRESS  |   |     | STREET ADDRESS   |   |  |
| CITY- ST- ZIP   |   |     | CITY- ST- ZIP  |   |  |
| TITLE   | <input type="checkbox"/> Delete                                 |     | TITLE  | <input type="checkbox"/> Change <input type="checkbox"/> Addition   |  |
| NAME  |   |     | NAME   |   |  |
| STREET ADDRESS  |   |     | STREET ADDRESS   |   |  |
| CITY- ST- ZIP   |   |     | CITY- ST- ZIP  |   |  |
| TITLE   | <input type="checkbox"/> Delete                                 |     | TITLE  | <input type="checkbox"/> Change <input type="checkbox"/> Addition   |  |
| NAME  |   |     | NAME   |   |  |
| STREET ADDRESS  |   |     | STREET ADDRESS   |   |  |
| CITY- ST- ZIP   |   |     | 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. |   |     |  |   |  |
| <b>SIGNATURE: <u>SIGNATURE REQUIRED</u></b><br><small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>  |   |     |  |   |  |
|   |   |     |  | Date _____ Daytime Phone # _____  |  |

CR2E034 (10/02)



90090807

FLORIDA DEPARTMENT OF STATE  
**Glenda E. Hood**  
Secretary of State

April 3, 2003

UNITED CHIROPRACTIC CENTER OF FLORIDA, INC.  
6565 TAFT STREET  
SUITE 404  
HOLLYWOOD, FL 33024

Subject: **UNITED CHIROPRACTIC CENTER OF FLORIDA, INC.**

Reference Number: **P02000081792**

Please be advised, we have received your annual report/uniform business report; however, the report **has not been filed** and a copy is being returned for the following correction(s):

The fee to file the enclosed profit annual report/uniform business report is **\$150.00**. If a certificate of status is desired, please add an additional \$8.75.

**TO AVOID THE \$400.00 LATE FEE, PLEASE RETURN THE CORRECTED REPORT TO: DIVISION OF CORPORATIONS, P.O. BOX 1500, TALLAHASSEE, FLORIDA 32302-1500 WITHIN 30 DAYS OF THE DATE OF THIS LETTER.**

If you have additional questions or need further assistance, please call the Division of Corporations at (850) 488-9000.

/md

ANNUAL REPORTS SECTION