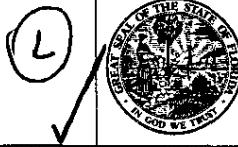


**2003 FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**

DOCUMENT # **P02000112676**

1. Entity Name

CCLL MEDICAL SUPPLIES, INC.



Principal Place of Business

514 LAKESIDE CIRCLE
SUNRISE FL 33326

Mailing Address

514 LAKESIDE CIRCLE
SUNRISE FL 33326

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

52-2384584

Applied For

Not Applicable

5. Certificate of Status Desired

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

LEON-LAURENT, MARIO
514 LAKESIDE CIRCLE
SUNRISE FL 33326

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

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
NAME
STREET ADDRESS
CITY-ST-ZIP

D
LEON-LAURENT, MARIO
514 LAKESIDE CIRCLE
SUNRISE FL 33326

Delete

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

P
LEON-LAURENT, MARIO
514 LAKESIDE CIRCLE
SUNRISE FL 33326

Change Addition

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

Delete

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

Change Addition

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CITY-ST-ZIP

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Change Addition

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Change Addition

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CITY-ST-ZIP

Delete

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

Change Addition

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 REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7-23-2003 (954) 294-3639

Date

Daytime Phone #

9/10/03 AV

CP2E034 (4/03)

Attachment

CCLL Medical Supplies Inc.
514 Lakeside Circle
Sunrise, FL 33326

July 23, 2003
Uniform Business Reports
Division of Corporations

901473483
PO2000112676

To Whom It May Concern:

I am writing to request a waiver of the late filing fee for the Uniform Business Report. Please be advised that CCLL Medical Supplies INC. did not receive a filing notice prior to the 60 day notice that the corporation will be administratively dissolved. I am sorry for the delay in filing and for all future years I will be sure to file in a timely manner.

Your consideration in this matter is greatly appreciated.

Thank you for your assistance,



Mario Leon-Laurent
President