

FILED
Jul 03, 2003 8:00 am
Secretary of State

06-13-2003 90057 030 ***150.00

2003 FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P02000120971	
1. Entity Name ALL-MED PATIENT TRANSPORT, INC.	
Principal Place of Business 5200 WELLINGTON PARK CIRCLE, CHS ORLANDO, FL 32839	Mailing Address 5200 WELLINGTON PARK CIRCLE, CHS ORLANDO, FL 32839
2. Principal Place of Business	3. Mailing Address P.O. Box 90303
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State Lakeland, FL
Zip	Country USA
4. FEI Number 01-0751493 Applied For Not Applicable	
5. Certificate of Status Desired ☐ \$3.75 Additional Fee Required	
6. Name and Address of Current Registered Agent HARRISON, TONY 6248 WELLINGTON PARK CIRCLE, A47 ORLANDO, FL 32839	
7. Name and Address of New Registered Agent Name Tony Harrison Street Address (P.O. Box Number is Not Acceptable) 5003 Elon Crescent City Lakeland FL Zip Code 33810	
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 a registered agent.	
SIGNATURE Tony Harrison Tony Harrison 6-10-03 Signature, dated or printed name of registered agent and date of certificate. PHOTO: Must have Agent signature stamped when submitted. DATE	
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	TITLE NAME STREET ADDRESS CITY-ST-ZIP
DPS HARRISON, TONY 6248 WELLINGTON PARK CIRCLE, A47 ORLANDO, FL 32839	DPS Harrison, Tony 5003 Elon Crescent Lakeland, FL 33810
TITLE NAME STREET ADDRESS CITY-ST-ZIP	TITLE NAME STREET ADDRESS CITY-ST-ZIP
DVPT ROWE, PAUL 5200 WELLINGTON PARK CIRCLE, CHS ORLANDO, FL 32839	
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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)(1), 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; that 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: I am empowered.	
SIGNATURE: [Signature] 6-10-03 407-832-1693 SIGNATURE AND TYPE OR PRINTED NAME OF REGISTERED OFFICE OR DIRECTOR DATE	

Attachment

55050440

P02000120971

All-Med Patient Transport, Inc

P.O. Box 90303
Lakeland, FL 33804
Tel: 863-528-4615
Fax: 877-485-8097

June 10, 2003

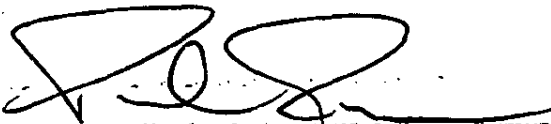
To Whom It May Concern:

I did not receive my letter of reinstatement from the Department of State Division of Corporations. I have spoken with a representative from the department who intern asked that I submit this letter with a check requested that all fees be waived due to non-receipt of any letters from your department.

Thank You in advance,

Sincerely,

Signature



Doc# - P-02000120971

Tax Id# 01-0751493