

FILED
Sep 29, 2004 8:00 am
Secretary of State

08-20-2004 90007 006 ***150.00
09-29-2004 90001 017 ***408.75

FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P03000029768	
1. Entity Name	
NORTHERN MEDICAL SERVICES INC	

DO NOT WRITE IN THIS SPACE

54073588

2. Principal Place of Business		3. Mailing Address	
255 E 34 ST			
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
HIALEAH, FL			
Zip	Country	Zip	Country
33010			

DO NOT WRITE IN THIS SPACE

4. FEI Number		Applied For	
38-3675630		<input type="checkbox"/> Not Applicable	
5. Certificate of Status Desired		<input type="checkbox"/> \$8.75 Additional Fee Required	

DO NOT WRITE IN THIS SPACE	7. Name and Address of Current Registered Agent		
	Name		
	ULLOA, ELIER		
	Street Address (P.O. Box Number is Not Acceptable)		
255 E 34 ST			
City		FL	Zip Code
HIALEAH			33013

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  **ULLOA, ELIER** **7/21/2004**
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

January 1 - May 1 Fee is \$150.00
After May 1, Fee is \$550.00
Amended UBR is \$61.25

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

Make Check Payable to Florida Department of State

10. OFFICERS AND DIRECTORS		11.	
TITLE	P	TITLE	
NAME	ULLOA, ELIER	NAME	
STREET ADDRESS	255 E 34 ST	STREET ADDRESS	
CITY-ST-ZIP	HIALEAH, FL 33013	CITY-ST-ZIP	
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE		TITLE	
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TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	

DO NOT WRITE IN THIS SPACE

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 on an attachment with an address, with all other like empowered.

SIGNATURE:  **ULLOA, ELIER, PRESIDENT** **7/21/2004** **(305) 633-9171**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #



Attachment
54073588

FLORIDA DEPARTMENT OF STATE

Glenda E. Hood
Secretary of State

August 25, 2004

NORTHERN MEDICAL SERVICES, INC.
255 E 34 ST
HIALEAH, FL 33013

SUBJECT: NORTHERN MEDICAL SERVICES, INC.
Ref. Number: P03000029768

We have received your document for NORTHERN MEDICAL SERVICES, INC. and your check(s) totaling \$150.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

The fee to file the profit annual report is \$150.00 plus \$400.00 late fee for a total of \$550.00. If a certificate of status is desired, please add an additional \$8.75.

There is a balance due of \$400.00. If a certificate of status is desired, please add an additional \$8.75

The only provision the Division of Corporations has for waiver of the \$400.00 late fee is if the annual report notice was not received. A letter stating this fact must accompany the completed annual report.

TO AVOID THE ADMINISTRATIVE DISSOLUTION/REVOCATION, 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 any questions concerning the filing of your document, please call (850) 245-6059.

Sean Toner
Senior Section Administrator

Letter Number: 304A00051879