2006 FOR PROFIT CORPORATION ANNUAL REPORT

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Secretary of State
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40099808

DOCUMENT # P03000036574

1. Entity Name
COLOMBIAN INSTITUTE OF ARTS AND ENTERTAINMENT CORP.

Principal Place of Business	Mailing Address
1040 WEST PROSPECT RD SUITE -D FORT LAUDERDALE, FL 33309	1040 WEST PROPECT RD SUITE - D FORT LAUDERDALE, FL 33309

DO NOT WRITE IN THIS SPACE

07122006 No Chg-P CR2E034 (11/05)

4. FEI Number
14-1878708
☐ Applied For
☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

GUTIERREZ, JESUS
240 N.E. 38 STREET
11
OAKLAND PARK, FL 33334

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE _____ DATE
Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS $150.00
Due by September 6, 2006

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

In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.

10. OFFICERS AND DIRECTORS

TITLE	PD
NAME	GUTIERREZ, JESUS
STREET ADDRESS	240 N.E. 38 STREET APT #11
CITY-ST-ZIP	OAKLAND PARK, FL 33334
TITLE	VD
NAME	GUTIERREZ, ANDREA
STREET ADDRESS	8030 HAMPTON BLVD # 411
CITY-ST-ZIP	NORTH LAUDERDALE, FL 33068
TITLE	TD
NAME	GUTIERREZ, MARIA N
STREET ADDRESS	240 N.E. 38 STREET APT # 11
CITY-ST-ZIP	OAKLAND PARK, FL 33334
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
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 exemptions contained in Chapter 119, 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: JESUS GUTIERREZ 07/06/06 964-587-9050
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

ATTACHMENT 400999808

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COLOMBIAN INSTITUTE OF ART AND ENTERTAINMENT CORP.
1040 W. PROSPECT ROAD SUITE D
OAKLAND PARK, FL 33309

FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS

TO WHOM IT MAY CONCERN:

On June 30th I received a notice of intent to dissolve. I was very surprised when I received this notice because I am a very responsible and honest person. I have never been behind with my bills or IRS taxes. Since the first day I open my business I have tried to manage my business the most correct and legal way possible to prevent these kind of issues. I never received any bill, letter, or anything like that about this payment, and unfortunately the company I hired to create my corporation never guided me the correct way and when I found out it was really late, many things where not completed . I remember one day I went to that company to talk to them about something with the corporation and the place was empty. They never called me or left a note saying that they where closing the office. I attempted to try to get my papers and everything they had from my corporation but that took me a good few months. Finally I hired a new accounting company and they are helping me and trying to fixed things.

I appeal to consider your decision on this penalty the corporation was created months before I was open for business. I am just starting, it has been very difficult for me to the point where I have to take money from my pocket to pay rent and sometimes other expenses from the institute besides this I was injured at my job on March 22, 2006 and on July 7, 2006 I had surgery. The doctor said it is going to take about two months or more for me to go back to work and to my regular activities.

I appreciate your attention in this matter and I hope you can help me with this. Thank you very much.

Sincerely,

JESUS F. GUTIERREZ

ATTACHMENT 40099808
#P03000036574

LAUDERDALE ORTHOPAEDIC SURGEONS

Michael J. Ruddy, M.D., P.A.
Raul T. Aparicio, M.D., P.A.
Michael C. Weiss, D.O., P.A.
Verano M. Hermida, M.D., P.A.
Domingo A. Delgado-Garcia, M.D., P.A.
Joel L. Rush, D.O.

South Florida Foot&Ankle Specialists

Paul M. Greenman, D.P.M., P.A.
Kevin P. Brady, D.P.M.
Alberto Herrada, D.P.M.

Patient Name: Gutierrez Jesus

Date: 6/28/06

Your outpatient surgery is scheduled at The Surgery Center of Fort Lauderdale on July 7 2006 1pm. They are located at 4485 N. State Road 7, Lauderdale Lakes. Their phone number is 954-735-0096.

Your pre-operative labs will be done at the surgery center, unless you are otherwise instructed. A nurse from the surgery center will contact you to obtain any additional information that may be needed.

On the day of your surgery please arrive one hour before your scheduled surgery time. Please be prompt on the day of your surgery or your surgery may be canceled or delayed.

A follow-up appointment has been arranged for July 10, 2006, 10:45 A.M.

The following prescription has been provides to you. Please fill this prescription prior to your surgery, but **DO NOT** take this medication until after your surgery.

Nothing to eat or drink after midnight the night before your surgery.
Elevate left/right upper/lower extremity on two pillows for 48 hours after surgery.
Keep dressing dry and intact until seen in office.
Use sling when ambulating.
Wear backbrace at all times.

Robin X317

■ Fort Lauderdale Office
1212 East Broward Boulevard
Fort Lauderdale, Florida 33301
(954) 462-1526
Fax: (954) 761-9625

Lauderdale Lakes Office
4850 West Oakland Park Boulevard
Lauderdale Lakes, Florida 33313
(954) 739-4420
Fax: (954) 733-4092

☐ Boca Raton Office
880 Northwest 13th Street, Suite 4A
Boca Raton, Florida 33486
(561) 417-4121
Fax: (561) 417-4122

☐ Davie Office
4301 S. Flamingo Road
Davie, Florida 33330
(954) 370-2135
Fax: (954) 370-2145

ATTACHMENT

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#P030000365 24

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
GALLAGHER BASSETT		
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
JESUS GUTIERREZ	4/18/45	137-94-6469
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician?
3/22/06	BANTA PROPERTIES, INC.	☐ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☒ No change in items 9 - 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: _____

12. Diagnosis(es): _____

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☒ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in items 20a - 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale: _____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) _____

☒ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☒ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

☐ f) Surgical Intervention - specify procedure(s): _____
☐ f_1) In-Office: _____
☐ f_2) Surgical Facility: _____
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care:

ATTACHMENT

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Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: JESUS GUTIERREZ Soc.Sec.#: 137-94-6469 D/A: 3/22/06 Visit/Review Date:

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21 No functional limitations identified or restrictions prescribed as of the following date: _

☒ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _ *Use additional sheet if needed.*

☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part _____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor/waist			
☐ Lift-waist/overhead			
☐ Pull			
☐ Push			
☐ Reach-Overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐ _			
☐ Other			

COMMENTS:

Other choices:Skin Contact/ Ex posure;Sensor y;Hand Dexterit y;Co gnitive;Crawl;Vision;Drive/O perate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration;Auditory;Specific ob Task(s);etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.

Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: _____ ☒ b) NO ☐ c) Anticipated MMI date: _____
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: e) ☐ Yes f) ☐ No
Comments: _

25. _ _ %Permanent Impairment Rating (body as a whole) Body part/system: _

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify _____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: _____

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation this patient, and have been shared with the patient." *"I certify to any MMI / PIR information provided in this form."*

Physician Group: LAUDERDALE ORTHO. SURG. Date: 7/10/06
Physician Signature: _____ Physician DOH License #: ME0048702
Physician Name: RAUL APARICIO, M.D. (print name) Physician Specialty: ORTHO. SURG.

If any direct patient services for this visit were rendered by a provider other than a physician, please complete section below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical regarding documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____ Provider DOH License #: _____
Provider Name: _____ (print name) Date: _____