

P03 00085827

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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PICK-UP

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MAIL

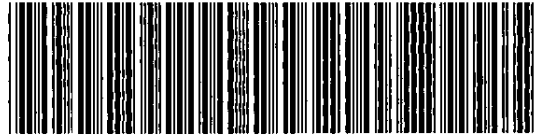
(Business Entity Name)

(Document Number)

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09 APR 28 PM 3:39

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

*Handwritten signature and date:*  
4/30

**COVER LETTER**

**TO:** Amendment Section  
Division of Corporations

**SUBJECT:** BEST CARE MEDICAL CENTER INC  
(Name of Corporation)

**DOCUMENT NUMBER:** P03000085827

The enclosed Statement of Change of Registered Office/Agent and fee are submitted for filing.  
Please return all correspondence concerning this matter to the following:

MARIO E AMADOR FELIPE  
(Name of Contact Person)

BEST CARE MEDICALCENTER INC  
(Firm/Company)

2702 W WATERS AVE  
(Address)

TAMPA FL 33614  
(City/State and Zip Code)

For further information concerning this matter, please call:

MARIO E AMADOR FELIPE at ( 786 ) 287-1567  
(Name of Contact Person) (Area Code & Daytime Telephone Number)

Enclosed is a \$35.00 check made payable to the Department of State.

**Mailing Address:**  
Amendment Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

**Street Address:**  
Amendment Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301



FLORIDA DEPARTMENT OF STATE  
Division of Corporations

April 15, 2009

MARIO E. AMADOR FELIPE  
BEST CARE MEDICAL CENTER, INC.  
2701 W WATERS AVE.  
TAMPA, FL 33614

SUBJECT: BEST CARE MEDICAL CENTER INC.  
Ref. Number: P03000085827

We have received your document for BEST CARE MEDICAL CENTER INC. and your check(s) totaling \$35.00. However, the enclosed document has not been filed and is being returned for the following correction(s):

Please complete the form in its entirety.

Please return your document, along with a copy of this letter, within 60 days or your filing will be considered abandoned.

If you have any questions concerning the filing of your document, please call (850) 245-6964.

Irene Albritton  
Regulatory Specialist II

Letter Number: 909A00012694

RECEIVED  
2009 APR 28 AM 8:00  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

**STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT OR BOTH  
FOR CORPORATIONS**

Pursuant to the provisions of sections 607.0502, 617.0502, 607.1508, or 617.1508, Florida Statutes, this statement of change is submitted for a corporation organized under the laws of the State of FLORIDA in order to change its registered office or registered agent, or both, in the State of Florida.

1. The name of the corporation: Best Care Medical Center
2. The principal office address: 2702 W. Waters Ave - Tampa, FL 33614
3. The mailing address (if different): Same as above ↑
4. Date of incorporation/qualification: 04-19-2009 Document number: P03000085827
5. The name and street address of the current registered agent and registered office on file with the Florida Department of State: (If resigned, enter resigned)

ARMANDO B ANGULO

2702 W WATERS AVE

TAMPA FL 33614

6. The name and street address of the new registered agent (if changed) and /or registered office (if changed):

MARIO E AMADOR FELIPE

180 E 37TH ST

(P.O. Box NOT acceptable)

HIALEAH FL 33013

The street address of its registered office and the street address of the business office of its registered agent, as changed will be identical.

Such change was authorized by resolution duly adopted by its board of directors or by an officer so authorized by the board, or the corporation has been notified in writing of the change.

\_\_\_\_\_  
(Signature of an officer or director)

\_\_\_\_\_  
(Printed or typed name and title)

*I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligation of my position as registered agent. Or, if this document is being filed merely to reflect a change in the registered office address, I hereby confirm that the corporation has been notified in writing of this change.*

  
\_\_\_\_\_  
(Signature of Registered Agent)

4-9-09  
\_\_\_\_\_  
(Date)

If signing on behalf of an entity:

\_\_\_\_\_  
(Typed or Printed Name)

**\*\*\* FILING FEE: \$35.00 \*\*\***

MAKE CHECKS PAYABLE TO FLORIDA DEPARTMENT OF STATE  
MAIL TO: DIVISION OF CORPORATIONS, P.O. BOX 6327, TALLAHASSEE, FL 32314  
CR2E045 (8/05)

FILED  
09 APR 28 PM 3:39  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA