

# 2004 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Feb 23, 2004 8:00 am**  
**Secretary of State**

02-09-2004 90029 011 \*\*\*150.00

**DOCUMENT # P03000088866**

1. Entity Name  
**DUBET HEALTH SERVICES, CORP.**



Principal Place of Business  
**953 SW 122 AVE  
MIAMI, FL 33184**

Mailing Address  
**953 SW 122 AVE  
MIAMI, FL 33184**

**66402870**



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

02052004

Chg-P

CR2E034 (10/03)

4. FEI Number

**20-0151657**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75 Additional  
Fee Required**

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**HERNANDEZ, BETTY  
953 SW 122 AVE  
MIAMI, FL 33184**

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]*

Signature, typewritten name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

**FILE NOW!!! FEE IS \$150.00  
After May 1, 2004 Fee will be \$550.00**

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  
HERNANDEZ, BETTY  
953 SW 122 AVE  
MIAMI, FL 33184** ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP  
**D  
MICHELL, DULCE M  
953 SW 122 AVE  
MIAMI, FL 33184** ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
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:

*[Signature]*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

Attachment  
#P03 000088866

66402820

<b>Form SS-4</b> (Rev. December 2001) Department of the Treasury Internal Revenue Service		<b>Application for Employer Identification Number</b> (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ See separate instructions for each line. ▶ Keep a copy for your records.		<b>EIN</b> <div style="border: 1px solid black; padding: 2px; display: inline-block;">20-0151657</div> OMB No. 1545-0003	
1* Legal name of entity (or individual) for whom the EIN is being requested <b>DUBET HEALTH SERVICES CORP</b>					
2 Trade name of business (if different from name on line 1)			3 Executor, trustee, "care of" name		
4a* Mailing address (room, apt., suite no. and street, or P.O. box) 953 SW 122 AVE			5a Street address (if different) (Do not enter a P.O. box)		
4b* City, state, and ZIP code MIAMI FL 33184 -			5b City, state, and ZIP code		
6* County and state where principal business is located County <b>MIAMI DADE</b> State <b>FL</b>					
7a* Name of principal officer, general partner, grantor, owner, or trustee <b>BETTY HERNANDEZ</b>			7b* SSN, ITIN, EIN 594-12-6832		
8a* Type of entity (check only one) <input type="checkbox"/> Sole Proprietor (SSN) <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ 1120S <input type="checkbox"/> Personal Service <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Other nonprofit organization (specify) ▶ <input type="checkbox"/> Other (specify) ▶			<input type="checkbox"/> Estate (SSN of decedent) <input type="checkbox"/> Plan administrator (SSN) <input type="checkbox"/> Trust (SSN of grantor) <input type="checkbox"/> National Guard <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> REMIC <input type="checkbox"/> State/local government <input type="checkbox"/> Federal government/military <input type="checkbox"/> Indian tribal government/enterprises Group Exemption NO. (GEN) ▶		
8b* If a corporation, name the state or foreign country (if applicable) where incorporated		State FL		Foreign country	
9* Reason for applying (check only one) <input checked="" type="checkbox"/> Started new business (specify type) ▶ <b>NURSING SERVICES</b> <input type="checkbox"/> Hired employees (Check the box and see line 12) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) ▶			<input type="checkbox"/> Banking purpose (specify purpose) ▶ <input type="checkbox"/> Changed type of organization (specify new type) ▶ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ <input type="checkbox"/> Created a pension plan (specify type) ▶		
10* Date business started or acquired (month, day, year) AUG 13 2003			11* Closing month of accounting year DEC		
12 First date wages or annuities were paid or will be paid (month, day, year) <i>Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year) .....</i> ▶					
13 Highest number of employees expected in the next twelve months <i>Note: If the applicant does not expect to have any employees during the period, enter "-0-".</i> ▶			Agriculture 0		Household 0
14* Check box that best describes the principal activity of your business <input type="checkbox"/> Construction <input type="checkbox"/> Real estate <input type="checkbox"/> Other (specify)			<input checked="" type="checkbox"/> Health care & social assistance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Retail		<input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Wholesale-other
15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. <b>NURSING SERVICES</b>					
16a* Has the applicant ever applied for an employer identification number for this or any other business? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>Note: If "Yes" please complete lines 16b and 16c</i>					
16b If you checked "Yes" on line 16a, give applicant's legal name and trade name shown on prior application if different from line 1 or 2 above. Legal name ▶ Trade name ▶					
16c Approximate date when, and city and state where, the application was filed. Enter previous employer identification number if known. Approximate date when filed (month, day, year) City and state where filed Previous EIN					
Complete section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form					
Third Party Designee	Designee's name <b>MILTON ARES</b> Address and ZIP code <b>3636 SW 87 AVE MIAMI FL 33165 -</b>			Designee's telephone number (include area code) ( 305 ) 229 - 8256 Designee's fax number (include area code) ( 305 ) 229 - 8252	
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete. Name and title (type or print clearly)				Applicant's telephone number (include area code)	