
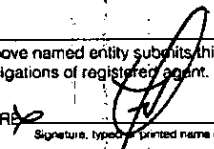
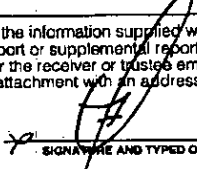


2004 FOR PROFIT CORPORATION ANNUAL REPORT

7/8/04

FILED
Jul 23, 2004 8:00 am
Secretary of State

07-08-2004 90096 039 ***150.00

DOCUMENT # P03000095382 1. Entity Name ORV MEDICAL SERVICES, INC.					
Principal Place of Business 13791 SW 66 STREET E-170 MIAMI, FL 33183			Mailing Address 13791 SW 66 STREET E-170 MIAMI, FL 33183		
2. Principal Place of Business Suite, Apt. #, etc.:			3. Mailing Address Suite, Apt. #, etc.:		
City & State			City & State		
Zip		Country		Zip	
Country		Country		4. FEI Number 20-0189481	
5. Certificate of Status Desired <input type="checkbox"/>				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent VILLEGAS, OSCAR C 13791 SW 66 STREET E-170 MIAMI, FL 33183				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City	
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.				FL Zip Code	
SIGNATURE 				DATE 7/6/04	
FILE NOW!!! FEE IS \$150.00 Due by September 8, 2004				9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$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			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P VILLEGAS, OSCAR C 13791 SW 66 STREET # E-170 MIAMI, FL 33183 <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP SILVEIRA, ROMY 13791 SW 66 STREET # E-170 MIAMI, FL 33183 <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> 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: 				DATE 7/6/04	
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR					

Attachment 66430514

Form **SS-4**(Rev December 2001)
Department of the Treasury
Internal Revenue Service**Application for Employer Identification Number**

(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.

EIN **20-0189481**

OMB No. 1545-0003

TYPE OR PRINT CLEARLY

1 Legal name of entity (or individual) for whom the EIN is being requested ORV Medical Services, Inc.		3 Executor, trustee, 'care of' name # P03000095380	
2 Trade name of business (if different from name on line 1)		5a Street address (if different) (do not enter a P.O. box)	
4a Mailing address (room, apartment, suite number, and street, or P.O. box) 13791 SW 66 Street # E-170		5b City State ZIP Code	
4b City State ZIP Code Miami FL 33183		5b City State ZIP Code	
6 County and state where principal business is located Dade, Florida			
7a Name of principal officer, general partner, grantor, owner, or trustor Oscar C. Villegas		7b SSN, ITIN, or EIN 595-**-2*4*	
8a Type of entity (check only one box)			
<input type="checkbox"/> Sole proprietor (SSN)		<input type="checkbox"/> Estate (SSN of decedent)	
<input type="checkbox"/> Partnership		<input type="checkbox"/> Plan administrator (SSN)	
<input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ 1120-S		<input type="checkbox"/> Trust (SSN of grantor)	
<input type="checkbox"/> Personal service corporation		<input type="checkbox"/> 'National' Guard	
<input type="checkbox"/> Church or church-controlled organization		<input type="checkbox"/> Farmers' cooperative	
<input type="checkbox"/> Other nonprofit organization (specify) ▶		<input type="checkbox"/> REMIC	
<input type="checkbox"/> Other (specify) ▶		Group Exemption Number (GEN) ▶	
8b If a corporation, name the state or foreign country (if applicable) where incorporated Florida		Foreign country	
9 Reason for applying (check only one box)			
<input checked="" type="checkbox"/> Started new business (specify type) ▶ Profit		<input type="checkbox"/> Banking purpose (specify purpose) ▶	
<input type="checkbox"/> Hired employees (check the box and see line 12.)		<input type="checkbox"/> Changed type of organization (specify new type) ▶	
<input type="checkbox"/> Compliance with IRS withholding regulations		<input type="checkbox"/> Purchased going business	
<input type="checkbox"/> Other (specify) ▶		<input type="checkbox"/> Created a trust (specify type) ▶	
<input type="checkbox"/>		<input type="checkbox"/> Created a pension plan (specify type) ▶	
10 Date business started or acquired (month, day, year) 09/01/03		11 Closing month of accounting year December	
12 First date wages or annuities were paid or will be paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶ NA			
13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter '0' ▶		Agricultural	Household
		0	0
14 Check one box that best describes the principal activity of your business.		<input type="checkbox"/> Wholesale-agent/broker	
<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input checked="" type="checkbox"/> Health care & social assistance	<input type="checkbox"/> Wholesale-other
<input type="checkbox"/> Real-estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Retail
<input type="checkbox"/>	<input type="checkbox"/> Finance & insurance	<input type="checkbox"/> Other (specify)	
15 Indicate principal line of merchandise sold, specific construction work done; products produced; or services provided. General Medical Services			
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 Note: If 'Yes,' please complete lines 16b and 16c.			
16b If you checked 'Yes' on line 16a, give applicant's legal name & 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 this 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.		
Designee's name		Designee's telephone number (include area code)
Address and ZIP code		Designee's fax number (include area code)

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.		Applicant's telephone number (include area code)
Name and title (type or print clearly.) ▶ Oscar C. Villegas, Pres		(305) 971-5246
Signature ▶		Applicant's fax number (include area code)

Date ▶ **09/01/03**