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Jul 23, 2004 8:00 am
Secretary of State

07-08-2004 90096 039 ***150.00

2004 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT # P03000095382

1. Entity Name
ORV MEDICAL SERVICES, INC.

66430514

07022004 Chg-P CR2E034 (10/03)

Principal Place of Business	Mailing Address
13791 SW 66 STREET E-170 MIAMI, FL 33183	13791 SW 66 STREET E-170 MIAMI, FL 33183
2. Principal Place of Business	3. Mailing Address
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. FEI Number 20-0189481 ☐ 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
VILLEGAS, OSCAR C 13791 SW 66 STREET E-170 MIAMI, FL 33183	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, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE 7/6/04

FILE NOW!!! FEE IS $150.00 Due by September 8, 2004	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			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	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VP SILVEIRA, ROMY 13791 SW 66 STREET # E-170 MIAMI, FL 33183	☐ 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date 7/6/04 Daytime Phone #

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. # P03000095380

2 Trade name of business (if different from name on line 1)

3 Executor, trustee, 'care of' name

4a Mailing address (room, apartment, suite number, and street, or P.O. box)
13791 SW 66 Street # E-170

5a Street address (if different) (do not enter a P.O. box)

4b City: Miami — State: FL — ZIP Code: 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)

- [ ] Sole proprietor (SSN) _____
- [ ] Partnership
- [X] Corporation (enter form number to be filed) ► 1120-S
- [ ] Personal service corporation
- [ ] Church or church-controlled organization
- [ ] Other nonprofit organization (specify) ►
- [ ] Other (specify) ►
- [ ] Estate (SSN of decedent)
- [ ] Plan administrator (SSN)
- [ ] Trust (SSN of grantor)
- [ ] National Guard
- [ ] State/local government
- [ ] Farmers' cooperative
- [ ] Federal government/military
- [ ] REMIC
- [ ] Indian tribal governments/enterprises

Group Exemption Number (GEN) ►

8b If a corporation, name the state or foreign country (if applicable) where incorporated: State: Florida — Foreign country:

9 **Reason for applying** (check only one box)

- [X] Started new business (specify type) ► Profit
- [ ] Hired employees (check the box and see line 12.)
- [ ] Compliance with IRS withholding regulations
- [ ] Other (specify) ►
- [ ] Banking purpose (specify purpose) ►
- [ ] Changed type of organization (specify new type) ►
- [ ] Purchased going business
- [ ] Created a trust (specify type) ►
- [ ] 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	Other
0	0	0

14 Check **one** box that best describes the principal activity of your business.

- [ ] Construction
- [ ] Real estate
- [ ] Rental & leasing
- [ ] Manufacturing
- [ ] Transportation & warehousing
- [ ] Finance & insurance
- [X] Health care & social assistance
- [ ] Accommodation & food service
- [ ] Other (specify)
- [ ] Wholesale-agent/broker
- [ ] Wholesale-other
- [ ] Retail

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? [ ] **Yes** [X] **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

Third Party Designee

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.

Name and title (type or print clearly.) ► Oscar C. Villegas, Pres

Applicant's telephone number (include area code): (305) 971-5246

Applicant's fax number (include area code)

Signature ►

Date ► 09/01/03

BAA For Privacy and Paperwork Reduction Act Notice, see separate instructions. FDIZ2901 07/24/02 Form **SS-4** (Rev 12-2001)