

2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Sep 17, 2004 8:00 am
Secretary of State

09-02-2004 90078 006 ***150.00

DOCUMENT # P03000143564

1. Entity Name
CARE SERVI MEDICAL EQUIPMENT CORP



Principal Place of Business
**2371 W 80 ST
B 6
HIALEAH, FL 33016 US**

Mailing Address
**2371 W 80 ST
B 6
HIALEAH, FL 33016 US**

66433800



2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

08262004

Chg-P

CR2E034 (10/03)

4. FEI Number

20-0444539

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

**LOPEZ, GREGORIO
2371 W 80 ST
B 6
HIALEAH, FL 33016**

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 resigning)

DATE

**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
LOPEZ, GREGORIO
2371 W 80 ST - B6
HIALEAH, FL 33016** ☐ Delete

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

TITLE
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CITY-ST-ZIP ☐ Delete

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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:

Gregorio Lopez Presit
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNED OFFICER OR DIRECTOR

9-14-04

Date

Exhibit Fee: \$

66433800

Attachment

Doc # 103000143564

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 20-0444539 OMB No. 1545-0003																						
1* Legal name of entity (or individual) for whom the EIN is being requested Care Servi Medical Equipment Corp																										
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) 11925 SW 12 St			5a Street address (if different) (Do not enter a P.O. box)																							
4b* City, state, and ZIP code Hialeah FL 33016			5b City, state, and ZIP code																							
6* County and state where principal business is located County Dade State FL																										
7a* Name of principal officer, general partner, grantor, owner, or trustee Gregorio Lopez			7b* SSN, ITIN, EIN 267-99-8199																							
8a* Type of entity (check only one) <table border="0"> <tr> <td><input type="checkbox"/> Sole Proprietor (SSN)</td> <td><input type="checkbox"/> Estate (SSN of decedent)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> Plan administrator (SSN)</td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ 1120</td> <td><input type="checkbox"/> Trust (SSN of grantor)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Personal Service</td> <td><input type="checkbox"/> National Guard</td> <td><input type="checkbox"/> State/local government</td> </tr> <tr> <td><input type="checkbox"/> Church or church-controlled organization</td> <td><input type="checkbox"/> Farmers' cooperative</td> <td><input type="checkbox"/> Federal government/military</td> </tr> <tr> <td><input type="checkbox"/> Other nonprofit organization (specify) ▶</td> <td><input type="checkbox"/> REMIC</td> <td><input type="checkbox"/> Indian tribal government/enterprises</td> </tr> <tr> <td><input type="checkbox"/> Other (specify) ▶</td> <td colspan="2">Group Exemption NO. (GEN) ▶</td> </tr> </table>						<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	<input type="checkbox"/> Trust (SSN of grantor)		<input type="checkbox"/> Personal Service	<input type="checkbox"/> National Guard	<input type="checkbox"/> State/local government	<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> Farmers' cooperative	<input type="checkbox"/> Federal government/military	<input type="checkbox"/> Other nonprofit organization (specify) ▶	<input type="checkbox"/> REMIC	<input type="checkbox"/> Indian tribal government/enterprises	<input type="checkbox"/> Other (specify) ▶	Group Exemption NO. (GEN) ▶	
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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) <table border="0"> <tr> <td><input checked="" type="checkbox"/> Started new business (specify type) ▶ Equipment Rental</td> <td><input type="checkbox"/> Banking purpose (specify purpose) ▶</td> </tr> <tr> <td><input type="checkbox"/> Hired employees (Check the box and see line 12)</td> <td><input type="checkbox"/> Changed type of organization (specify new type) ▶</td> </tr> <tr> <td><input type="checkbox"/> Compliance with IRS withholding regulations</td> <td><input type="checkbox"/> Purchased going business</td> </tr> <tr> <td><input type="checkbox"/> Other (specify) ▶</td> <td><input type="checkbox"/> Created a trust (specify type) ▶</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Created a pension plan (specify type) ▶</td> </tr> </table>						<input checked="" type="checkbox"/> Started new business (specify type) ▶ Equipment Rental	<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"/> Created a pension plan (specify type) ▶											
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10* Date business started or acquired (month, day, year) DEC 1 2003			11* Closing month of accounting year JAN																							
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> ▶ JAN 1 2004																										
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																					
				Other 1																						
14* Check box that best describes the principal activity of your business <table border="0"> <tr> <td><input type="checkbox"/> Construction</td> <td><input type="checkbox"/> Rental & leasing</td> <td><input type="checkbox"/> Transportation & warehousing</td> <td><input checked="" type="checkbox"/> Health care & social assistance</td> <td><input type="checkbox"/> Wholesale-agent/broker</td> </tr> <tr> <td><input type="checkbox"/> Real estate</td> <td><input type="checkbox"/> Manufacturing</td> <td><input type="checkbox"/> Finance & insurance</td> <td><input type="checkbox"/> Accommodation & food service</td> <td><input type="checkbox"/> Wholesale-other</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other (specify)</td> <td><input type="checkbox"/> Retail</td> <td></td> </tr> </table>						<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input checked="" type="checkbox"/> Health care & social assistance	<input type="checkbox"/> Wholesale-agent/broker	<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale-other	<input type="checkbox"/> Other (specify)			<input type="checkbox"/> Retail							
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15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. Medical Equipment Rental																										
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 <table border="0"> <tr> <td rowspan="3">Third Party Designee</td> <td>Designee's name</td> <td>Designee's telephone number (include area code)</td> </tr> <tr> <td>Address and ZIP code</td> <td>() -</td> </tr> <tr> <td></td> <td>Designee's fax number (include area code)</td> </tr> <tr> <td></td> <td></td> <td>() -</td> </tr> </table>						Third Party Designee	Designee's name	Designee's telephone number (include area code)	Address and ZIP code	() -		Designee's fax number (include area code)			() -											
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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)																						