

2004 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
May 10, 2004 8:00 am
Secretary of State

04-19-2004 90361 010 ***150.00

DOCUMENT # P03000146822

1. Entity Name

EXCELLENT CARE CHIROPRACTIC CENTER INC.



Principal Place of Business

6595 NW 36TH ST SUITE 304-2
MIAMI FL 33166

Mailing Address

6595 NW 36TH ST SUITE 304-2
MIAMI FL 33166

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country



MOORE

CR2E034 (11/03)

4. FEI Number

59-3773541

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

SIMON, ORLAIDA
11061 SW 63RD TERRACE
MIAMI FL 33173

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

FILE NOW!!! FEE IS \$150.00

After May 1, 2004 Fee will be \$550.00

Make Check Payable to Florida Department of State

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 PD
NAME SIMON, ORLAIDA
STREET ADDRESS 6595 NW 36TH ST SUITE 304-2
CITY- ST- ZIP MIAMI FL 33166

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STREET ADDRESS
CITY- ST- ZIP

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:

Orlaida Simon - Pres
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4/16/04

305-871-9087

Date

Daytime Phone #