

2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Sep 04, 2007 8:00 am
Secretary of State

09-04-2007 90039 014 ***228.75

DOCUMENT # P05000007523 1. Entity Name BEST CARE FOR YOUR HEALTH MEDICAL CENTER INC					
Principal Place of Business 4201 PALM AVE., STE 2D HIALEAH, FL 33012			Mailing Address 4201 PALM AVE., STE 2D HIALEAH, FL 33012		
2. Principal Place of Business - No P.O. Box #		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country	4. FEI Number 20-2173439	
5. Certificate of Status Desired <input type="checkbox"/>				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent NOLASCO, ANGEL 4201 PALM AVE., STE 2D HIALEAH, FL 33012				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> FL Zip Code </div>	
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 _____ <small>Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE</small>					
FILE NOW!!! FEE IS \$150.00 Due by September 14, 2007		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	VD NOLASCO, ANGEL 4201 PALM AVE., STE 2D HIALEAH, FL 33012 <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	PD HERNANDES, LOURDES 4201 PALM AVE., STE 2D HIALEAH, FL 33012 <input checked="" 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	T BARRIONUEVO, ILIANA MORO 4201 PALM AVE., STE 2D HIALEAH, FL 33012 <input checked="" 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 exemptions contained in Chapter 119, 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 _____ Daytime Phone # _____					

40131000



08272007 Chg-P CR2E034 (12/06)

4. FEI Number
20-2173439

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**

7. Name and Address of New Registered Agent
Name
Street Address (P.O. Box Number is Not Acceptable)
City
FL Zip Code

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.

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 TITLE NAME STREET ADDRESS CITY- ST- ZIP TITLE NAME STREET ADDRESS CITY- ST- ZIP TITLE NAME STREET ADDRESS CITY- ST- ZIP TITLE NAME STREET ADDRESS CITY- ST- ZIP TITLE NAME STREET ADDRESS CITY- ST- ZIP TITLE NAME STREET ADDRESS CITY- ST- ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Change <input type="checkbox"/> Addition
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ATTACHMENT
40131039

COVER LETTER

TO: Amendment Section
Division of Corporations

SUBJECT: BEST CARE FOR YOUR HEALTH MEDICAL CENTER, INC.

(Name of Corporation)

DOCUMENT NUMBER: P05000007528

The enclosed Officer/Director Resignation for a Corporation and fee are submitted for filing.

Please return all correspondence concerning this matter to the following:

ANGEL NOLASCO

(Name of Person)

BEST CARE FOR YOUR HEALTH MEDICAL CENT

(Name of Firm/Company)

2540 NW 7TH ST

(Address)

MIAMI, FL 33125

(City/State and Zip Code)

For further information concerning this matter, please call:

ANGEL NOLASCO

(Name of Person)

at (305) 643-6007

(Area Code & Daytime Telephone Number)

Enclosed is a check for \$35.00 made payable to the Florida Department of State.

Street Address:

Amendment Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, FL 32301

Mailing Address:

Amendment Section
Division of Corporations
Post Office Box 6327
Tallahassee, FL 32314

ATTACHMENT

40131039

#P05000007523

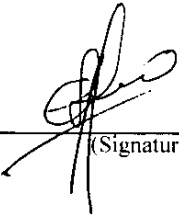
**OFFICER / DIRECTOR RESIGNATION
FOR A CORPORATION**

I, LOURDES HERNANDEZ, hereby resign as PRESIDENT
(Title)

of BEST CARE FOR YOUR HEALTH MEDICAL CENTER, INC.
(Name of Corporation)

P05000007523, a corporation organized under the laws of the State of
(Document Number, if known)

FLORIDA


(Signature of resigning officer/director)

FILING FEE IS \$35.00

Make checks payable to Florida Department of State and mail to:

Amendment Section
Division of Corporations
P.O. Box 6327
Tallahassee, Florida 32314

ATTACHMENT 40131039

#P05000007523

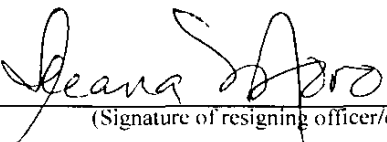
**OFFICER / DIRECTOR RESIGNATION
FOR A CORPORATION**

I, ILIANA MORO BARRIONUEVO, hereby resign as TREASURER
(Title)

of BEST CARE FOR YOUR HEALTH MEDICAL CENTER, INC.
(Name of Corporation)

P05000007523, a corporation organized under the laws of the State of
(Document Number, if known)

FLORIDA


(Signature of resigning officer/director)

FILING FEE IS \$35.00

Make checks payable to Florida Department of State and mail to:

Amendment Section
Division of Corporations
P.O. Box 6327
Tallahassee, Florida 32314