

2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 24, 2008 08:00 AM
Secretary of State

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	



04212008 No Chg-P CR2E034 (11/05)

4. FEI Number 20-2173439	Applied For ☐ Not Applicable
5. Certificate of Status Desired ☐ \$8.75 Additional Fee Required	

DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent NOLASCO, ANGEL 4201 PALM AVE., STE 2D HIALEAH, FL 33012	DO NOT WRITE IN THIS SPACE
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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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

**FILE NOW!!! FEE IS \$150.00
After May 1, 2008 Fee will be \$550.00**

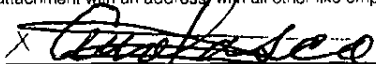
9. Election Campaign Financing Trust Fund Contribution ☐ **\$5.00 May Be Added to Fees**

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P NOLASCO, ANGEL 4201 PALM AVE., STE 2D HIALEAH, FL 33012
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05/13/08-80110-017 150.00

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 # _____