

2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
May 12, 2006 8:00 am
Secretary of State

04-24-2006 90444 013 ***150.00

DOCUMENT # P05000018415 1. Entity Name HUMAN COMPETITIVE CARE SERVICES, INC.					
Principal Place of Business 6595 NW 36 ST. SUITE 319 MIAMI, FL 33166			Mailing Address 6595 NW 36 ST. SUITE 319 MIAMI, FL 33166		
2. Principal Place of Business Suite, Apt. #, etc. City & State Zip Country			3. Mailing Address Suite, Apt. #, etc. City & State Zip Country		
4. FEI Number 20-22 89719				Applied For ☐ Not Applicable	
5. Certificate of Status Desired ☐				\$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent MANSO, JESUS 7565 SW 28 STREET MIAMI, FL 33155			7. Name and Address of New Registered Agent 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 re-registering) DATE					
FILE NOW!!! FEE IS \$150.00 After May 1, 2006 Fee will be \$550.00		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 NAME STREET ADDRESS CITY-ST-ZIP	P MANSO, JESUS 7565 SW 28 STREET MIAMI, FL 33155 ☐ Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition	
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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 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: <i>[Signature]</i>			<i>President</i>		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR			Date		

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04052006 Chg-P CR2E034 (11/05)

ATTACHMENT

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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 20-2289719 OMB No. 1545-0003	
1* Legal name of entity (or individual) for whom the EIN is being requested HUMAN COMPETITIVE CARE SERVICES INC					
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) 6585 NW 36 STREET SUITE 319			5a Street address (if different) (Do not enter a P.O. box)		
4b* City, state, and ZIP code MIAMI FL 33188			5b City, state, and ZIP code		
6* County and state where principal business is located County MIAMI DADE State FL					
7a* Name of principal officer, general partner, grantor, owner, or trustee JESUS MANSO			7b* SSN, TIN, EIN 888-98-8288		
8a* Type of entity (check only one) ☐ Sole Proprietor (SSN) ☐ Partnership ☒ Corporation (enter form number to be filed) ▶ 1120 S ☐ Personal Service ☐ Church or church-controlled organization ☐ Other nonprofit organization (specify) ▶ ☐ Other (specify) ▶					
☐ Estate (SSN of decedent) ☐ Plan administrator (SSN) ☐ Trust (SSN of grantor) ☐ National Guard ☐ Farmers' cooperative ☐ REMIC Group Exemption NO. (GEN) ▶					
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) ☒ Started new business (specify type) ▶ MEDICAL CARE ☐ 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) FEB 3 2005			11* Closing month of accounting year DEC		
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> ▶ JUN 1 2005					
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 ☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Other (specify) ▶					
☒ Health care & social assistance ☐ Accommodation & food service ☐ Retail ☐ Wholesale-agent/broker ☐ Wholesale-other					
15* Indicate principal line of merchandise sold; specific construction work done; products produced; or services provided. MEDICAL CARE					
16a* Has the applicant ever applied for an employer identification number for this or any other business? ☐ Yes ☒ 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					
Third Party Designee		Designee's name Address and ZIP code		Designee's telephone number (include area 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)				Applicant's telephone number (include area code)	