

ARTICLES OF INCORPORATION
In compliance with Chapter 607 and/or Chapter 621, F.S. (Profit)

ARTICLE I NAME

The name of the corporation shall be: E- Pharmacy Tech Program, Inc.

ARTICLE II PRINCIPAL OFFICE

Principal street address
1875 NW 100th Way

Mailing address, if different is:
P. O. Box 245126

Pembroke Pines, Florida 33024

Pembroke Pines, Florida 33024

ARTICLE III PURPOSE

The purpose for which the corporation is organized is: _____

To provide an online learning program; as well as any and all lawful business.

ARTICLE IV SHARES

The number of shares of stock is: 100

ARTICLE V INITIAL OFFICERS AND/OR DIRECTORS

Name and Title: Ruth Cash, President Name and Title: _____

Address 1875 NW 100th Way Address: _____

Pembroke Pines, Florida 33024 _____

Name and Title: _____ Name and Title: _____

Address _____ Address: _____

Name and Title: _____ Name and Title: _____

Address _____ Address: _____

Name and Title: _____ Name and Title: _____
Address _____ Address: _____

ARTICLE VI REGISTERED AGENT

The **name and Florida street address** (P.O. Box NOT acceptable) of the registered agent is:

Name: Ruth Cash
Address: 1875 NW 100th Way
Pembroke Pines, Florida 33024

ARTICLE VII INCORPORATOR

The **name and address** of the Incorporator is:

Name: Ruth Cash
Address: 1875 NW 100th Way
Pembroke Pines, Florida 33024

2020 JUN -9 PM 11:18
FILED
TALLAHASSEE, FLORIDA


ARTICLE VIII EFFECTIVE DATE:

Effective date, if other than the date of filing: _____ (OPTIONAL)

(If an effective date is listed, the date must be specific and cannot be more than five days prior or 90 days after the filing.)

Note: If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as the document's effective date on the Department of State's records.

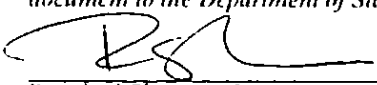
Having been named as registered agent to accept service of process for the above stated corporation at the place designated in this certificate, I am familiar with and accept the appointment as registered agent and agree to act in this capacity



Required Signature/Registered Agent

5/28/2020
Date

I submit this document and affirm that the facts stated herein are true. I am aware that the false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.



Required Signature/Incorporator

5/28/2020
Date

Application for Employer Identification Number
 (For use by employers, corporations, partnerships, trusts, estates, churches,
 government agencies, Indian tribal entities, certain individuals, and others.)
 ▶ Go to www.irs.gov/FormSS4 for instructions and the latest information.
 ▶ See separate instructions for each line. ▶ Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.		1 Legal name of entity (or individual) for whom the EIN is being requested E-Pharmacy Tech Program, Inc.	
2 Trade name of business (if different from name on line 1)		3 Executor, administrator, trustee, "care of" name	
4a Mailing address (room, apt., suite no. and street, or P.O. box) P. O. Box 245126		5a Street address (if different) (Don't enter a P.O. box.) 1875 NW 100th Way	
4b City, state, and ZIP code (if foreign, see instructions) Pembroke Pines, Florida 33024		5b City, state, and ZIP code (if foreign, see instructions) Pembroke Pines, Florida 33024	
6 County and state where principal business is located Broward County, Florida			
7a Name of responsible party Ruth Cash		7b SSN, ITIN, or EIN 592-21-7426	
8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members ▶	
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check.			
<input type="checkbox"/> Sole proprietor (SSN) _____		<input type="checkbox"/> Estate (SSN of decedent) _____	
<input type="checkbox"/> Partnership _____		<input type="checkbox"/> Plan administrator (TIN) _____	
<input checked="" type="checkbox"/> Corporation (enter form number to be filed) ▶ 1120		<input type="checkbox"/> Trust (TIN of grantor) _____	
<input type="checkbox"/> Personal service corporation _____		<input type="checkbox"/> Military/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	
<input type="checkbox"/> Other nonprofit organization (specify) ▶ _____		<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises	
<input type="checkbox"/> Other (specify) ▶ _____		Group Exemption Number (GEN) if any ▶ _____	
9b If a corporation, name the state or foreign country (if applicable) where incorporated		State Florida	Foreign country
10 Reason for applying (check only one box)			
<input checked="" type="checkbox"/> Started new business (specify type) ▶ _____		<input type="checkbox"/> Banking purpose (specify purpose) ▶ _____	
Online Education Program		<input type="checkbox"/> Changed type of organization (specify new type) ▶ _____	
<input type="checkbox"/> Purchased going business		<input type="checkbox"/> Created a trust (specify type) ▶ _____	
<input type="checkbox"/> Hired employees (Check the box and see line 13.)		<input type="checkbox"/> Created a pension plan (specify type) ▶ _____	
<input type="checkbox"/> Compliance with IRS withholding regulations			
<input type="checkbox"/> Other (specify) ▶ _____			
11 Date business started or acquired (month, day, year). See instructions. June 30, 2020		12 Closing month of accounting year	
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$5,000 or less in total wages.) If you don't check this box, you must file Form 941 for every quarter. <input type="checkbox"/>	
Agricultural 0	Household 0	Other 0	
15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶			
16 Check one box that best describes the principal activity of your business.			
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing		<input 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"/> Retail	
<input checked="" type="checkbox"/> Other (specify) ▶ Online Education			
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. Online Pharmacy Technician Program			
8 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," write previous EIN here ▶ 26-1344610			
Third party designee	Complete this 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.		
	Designee's name		Designee's telephone number (include area code)
	Address and ZIP 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.			Applicant's telephone number (include area code)
Signature and title (type or print clearly) ▶			Applicant's fax number (include area code)
Signature ▶			Date ▶

COVER LETTER

Department of State
New Filing Section
Division of Corporations
P. O. Box 6327
Tallahassee, FL 32314

Copy

SUBJECT: E- Pharmacy Tech Program, Inc.
(PROPOSED CORPORATE NAME - MUS)

Enclosed are an original and one (1) copy of the articles of incorporation and a check for:

\$70.00 Filing Fee
 \$78.75 Filing Fee & Certificate of Status

\$78.75 Filing Fee & Certified Copy
 \$87.50 Filing Fee, Certified Copy & Certificate of Status
ADDITIONAL COPY REQUIRED

FROM: Ruth Cash
Name (Printed or typed)

1875 NW 100th Way
Address

Pembroke Pines, Florida 33024
City, State & Zip

954-297-9398
Daytime Telephone number

cash04395@gmail.com
E-mail address: (to be used for future annual report notification)

NOTE: Please provide the original and one copy of the articles.

ARTICLES OF INCORPORATION

In compliance with Chapter 607 and/or Chapter 621, F.S. (Profit)

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Name and Title: Ruth Cash, President Name and Title: _____

Address 1875 NW 100th Way Address: _____
Pembroke Pines, Florida 33024 _____

Name and Title: _____ Name and Title: _____

Address _____ Address: _____

Name and Title: _____ Name and Title: _____

Address _____ Address: _____

Name and Title: _____ Name and Title: _____
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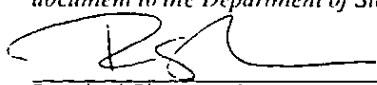
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<input type="checkbox"/> Banking purpose (specify purpose) ▶ _____ <input type="checkbox"/> Changed type of organization (specify new type) ▶ _____ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> Created a pension plan (specify type) ▶ _____		
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Designee	Address and ZIP 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.		Applicant's telephone number (include area code)
Signature ▶		Applicant's fax number (include area code)
Date ▶		