2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 23, 2003 8:00 am
Secretary of State
04-23-2003 90069 032 ***150.00

11007469

DOCUMENT # P93000040839

1. Entity Name
THE CHEST PAIN CLINIC, INC.

Principal Place of Business	Mailing Address
777 E. 25 ST SUITE #112 HIALEAH FL 33013	777 E. 25 ST SUITE #112 HIALEAH FL 33013

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

☐ CHECK HERE IF MAKING CHANGES

4. FEI Number 65-0426430 ☐ 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
LORA, JULIO C 777 E. 25 ST SUITE #112 HIALEAH FL 33013	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, 2003 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 NAME STREET ADDRESS CITY-ST-ZIP	DPST LORA, JULIO C 777 E. 25 ST #112 HIALEAH FL 33013 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
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CR2E034 (10/02)

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: SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

Attachment #

Jose R. Gomez C.P.A., P.A.
CERTIFIED PUBLIC ACCOUNTANT
782 N.W. LE JEUNE RD. - SUITE 447 - MIAMI, FLORIDA 33126
TEL: (305) 447-0400 - FAX: (305) 447-9101

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TO: THE CHEST PAIN CLINIC INC DATE: 1-23-2003

INSTRUCTIONS FOR FILING THE ATTACHED TAX RETURN

RETURN ENCLOSED

FORM# UNIFORM BUSINESS REPORT (UBR)

YEAR 2003

F.Y.E

TO BE SIGNED AND DATED BY

☐ TAXPAYER ☒ AN OFFICER ☐ AFFIX CORPORATE SEAL
☐ TAXPAYER AND SPOUSE ☐ ANY PARTNER ☐ NOTARIZATION
☐ .....

(PLEASE SIGN AND DATE WHERE "X" APPEARS. ALSO SIGN AND DATE RETAINDED COPY FOR RECORD PURPOSES.)

AMOUNT OF TAX

☐ **NONE**

☐ THIS IS A YEAR-END RETURN.
Your estimated payments amounted to $.....
Your balance is due, as follows:

With Return Due on: 4/30 20 03 $ 150.00
Balance on ..... 20 ..... $.....

MAKE CHECK PAYABLE TO

☐ INTERNAL REVENUE SERVICE ☒ DEPARTMENT OF STATE

☐ Your authorized commercial bank depositary of Federal Reserve Bank. Deposit check with bank before due date, accompanied by appropriate coupon. Mark type of tax _____

☐ **MAIL RETURN ONLY, TO:**

☒ **MAIL RETURN AND CHECK, TO:**

☐ INTERNAL REVENUE SERVICE
☐ .....
☐ .....

☒ AT: DIVISION OF CORPORATIONS
UNIFORM BUSINESS REPORT FILINGS
P.O. BOX 1500
TALLAHASSEE, FL. 32302-1500

DUE DATE APRIL 30, 2003

OVER-PAYMENT

YOUR RETURN SHOWS AN OVERPAYMENT OF $_____
WE HAVE INDICATED ON THE RETURN THAT SUCH AMOUNT
☐ $ _____ WILL BE APPLIED AGAINST YOUR ESTIMATED TAX FOR _____
☐ $ _____ IS TO BE REFUNDED TO YOU AUTOMATICALLY.

REMARKS