

2001 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P93000074422

1. Entity Name
AGAPE NURSING SERVICES, INC.

FILED
Apr 10, 2001 8:00 am
Secretary of State

04-10-2001 90141 008 ***150.00

Principal Place of Business 201 SW PORT ST LUCIE BLVD SUITE #108 PORT ST LUCIE FL 34984 US	Mailing Address 201 SW PORT ST LUCIE BLVD SUITE #108 PORT ST LUCIE FL 34984 US
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00033844



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business 402 SW Eyerly Ave Suite, Apt. #, etc.	3. Mailing Address 402 SW Eyerly Ave Suite, Apt. #, etc.
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City & State Port St Lucie, FL	City & State Port St Lucie, FL
Zip 34983	Zip 34983
Country USA	Country USA

4. FEI Number 65-0449696	Applied For <input type="checkbox"/> Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
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6. Name and Address of Current Registered Agent BACHMANN, JAYCINTH 402 S W EYERLY AVE PORT ST LUCIE FL 34983	7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code
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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.

SIGNATURE *[Signature]* (N.O.T.E: Registered Agent signature required when reinstating) DATE *4-9-01*

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. <input type="checkbox"/> (See criteria on back)	FILE NOW!!! FEE IS \$150.00 After MAY 1, 2001 Fee will be \$550.00 Make Check Payable to Department of State	10. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees
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11. OFFICERS AND DIRECTORS			12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE	DP	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	BACHMANN, JAYCINTH		NAME		
STREET ADDRESS	402 SW EYERLY AVE		STREET ADDRESS		
CITY-ST-ZIP	PORT ST LUCIE FL		CITY-ST-ZIP		
TITLE	D	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	BACHMANN, DANIEL		NAME		
STREET ADDRESS	402 SW EYERLY AVE		STREET ADDRESS		
CITY-ST-ZIP	PORT ST LUCIE FL		CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		

13. 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 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: *[Signature]* **Daniel Bachmann** 4-4-01 561-343-7800
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/00)