

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Aug 25, 2003 8:00 am
Secretary of State

08-25-2003 90097 001 ***150.00

0048301 AV

DOCUMENT # P94000093625

1. Entity Name
INSTITUTE OF HEALTH, INC.



Principal Place of Business

6445 S W 8 ST.
MIAMI FL 33144

Mailing Address

6445 S.W. 8TH STREET
MIAMI FL 33144
US

2. Principal Place of Business

3. Mailing Address

PO Box 51157

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Punta Gorda, FL

Zip

Country

Zip

3395

Country

USA

4. FEI Number

65-0543522

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

HELLMAN, MAYNARD J
1100 PONCE DE LEON BLVD
CORAL GABLES FL 33134

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 \$550.00
After September 10, 2003 Fee will be \$750.00
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	DPA	<input type="checkbox"/> Delete
NAME	VALLADARES, JEANNETTE	
STREET ADDRESS	6445 SW 8 STREET	
CITY-ST-ZIP	MIAMI FL 33144	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
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STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

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 #

CR2E034 (4/03)

Attachment #

INSTITUTE OF HEALTH, INC.

PO BOX 511157
PUNTA GORDA, FL. 33951
941-628-3590

80140799
P94000093625

AUGUST 18, 2003

TO WHOM IT MAY CONCERN:

**PLEASE WAIVE OUR LATE FEE SINCE THIS IS THE FIRST NOTICE
WE RECEIVED FOR INSTITUTE OF HEALTH, INC.
(DOC.# P94000093625). WE CHANGED OUR MAILING ADDRESS,
BUT APPARENTLY IT WAS NOT REGISTERED.**

**ALSO, PLEASE SEND ME ANY ADDITIONAL FORMS I NEED TO
CHANGE MY ADDRESS CORRECTLY.**

THANK YOU VERY MUCH,


JEANNETTE VALLADARES