

2001 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P95000006322

1. Entity Name

MAXI-CARE, INC.

FILED
Jan 29, 2001 8:00 am
Secretary of State

01-29-2001 90160 032 ***150.00

Principal Place of Business

Mailing Address

701 N. CONGRESS AVE.
SUITE 9-10
BOYNTON BEACH FL 33426

701 N. CONGRESS AVE.
SUITE 9-10
BOYNTON BEACH FL 33426

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number **65-0550464**

Applied For

Not Applicable

Zip

Country

Zip

Country

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

WILLIAMS, SALVADOR A M.D.
701 N. CONGRESS AVE.
SUITE 9-10
BOYNTON BEACH FL 33426

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.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

9. This corporation is eligible to satisfy its Intangible
Tax filing requirement and elects to do so.
(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. ☐

\$5.00 May Be
Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P WILLIAMS, SALVADOR A M.D. 4825 BELVEDERE RD. WEST PALM BEACH FL 33415	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST WILLIAMS, RUTH 4825 BELVEDERE WEST PALM BEACH FL 33415	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

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: *X Salvador A. Williams M.D.*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (10/00)