2005 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Jun 24, 2005 8:00 am
Secretary of State
06-24-2005 90003 011 ***550.00

DOCUMENT # P95000024896

1. Entity Name
MAN'S BEST FRIEND, INC.

Principal Place of Business	Mailing Address
MANS BEST FRIEND INC 4826 NW 2ND AVE BOCA RATON, FL 33431	MANS BEST FRIEND INC 4826 NW 2ND AVE BOCA RATON, FL 33431

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

06152005 Chg-P CR2E034 (10/03)

4. FEI Number
65-0576400
☐ Applied For
☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

BOLANDER, TIM
4826 NW 2ND AVE
BOCA RATON, FL 33431

7. Name and Address of New Registered Agent

Name LIDIA BOLANDER
Street Address (P.O. Box Number is Not Acceptable) 4826 NW 2nd Ave.
City Boca Raton FL Zip Code 33431

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 Lidia Bolander 05/31/2005
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
Due by September 7, 2005

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	P BOLANDER, TIM 3820 ARELIA DR.S DELRAY BEACH, FL 33445	☑ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	LIDIA BOLANDER 4826 NW 2nd Ave. Boca Raton, FL 33431	☑ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	JEFF BOLANDER 4826 NW 2nd Ave. Boca Raton, FL 33431	☐ Change ☑ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ 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
TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ 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

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] / Lidia Bolander 6-15-05 561 4440533
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

561-241-1711

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

ATTACHMENT

400893390

#P95000024896

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO. 6004-13549

CERTIFICATE OF DEATH
FLORIDA

DECEDENT

1. DECEDENT'S NAME (First / Middle / Last)			2. SEX
Timothy	Martin	Bolander	Male

3. DATE OF DEATH (Month, Day, Year)	4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (years)	5b. UNDER 1 YEAR – Months	Days	5c. UNDER 1 Day – Hours	Minutes
December 23, 2004	285-64-7713	31				

6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)	9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)
April 4, 1973	Willoughby, Ohio	No

9a. PLACE OF DEATH (Check only one; see instructions on other side)

HOSPITAL: ___ Inpatient X ER/Outpatient ___ DOA OTHER: ___ Nursing Home ___ Residence ___ Other (Specify)

9b. INSIDE CITY LIMITS? (Yes or No): Yes No

9c. FACILITY NAME (If not institution, give street and number)	9d. CITY, TOWN, OR LOCATION OF DEATH	9e. COUNTY OF DEATH
Delray Medical Center	Delray Beach	Palm Beach

10a. DECEDENT'S USUAL OCCUPATION	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	12. SURVIVING SPOUSE (If wife, give maiden name)
Owner/Operator	Dog Training	Married	Lidia Maria Dziopko

PARENTS

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Florida	Palm Beach	Delray Beach	1730 Satin Leaf Court

13e. INSIDE CITY LIMITS? (Yes or No)	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes – If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) X No ___ Yes Specify:	15. RACE – American Indian, Asian, Black, White, etc. Specify:	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0 - 12)	College (1-4 or 5 +)
Yes	33445		White	12	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Timothy E. Bolander	Jody A. Schafer

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lidia Bolander	1730 Satin Leaf Ct., Delray Beach, FL33445

DISPOSITION

20a. METHOD OF DISPOSITION: ___ Burial X Cremation ___ Removal from State ___ Donation ___ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION – City or Town, State
ABCO Crematory	Ft. Lauderdale, Florida

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (of Licensee)	21c. NAME AND ADDRESS OF FACILITY
	FE #3892	Gary Panoch Funeral Home & Crematior 6140 N. Fed. Hwy, Boca Raton, FL33487

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only

22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. (Signature and Title)

22b. DATE SIGNED (Mo., Day, Yr)	22c. HOUR OF DEATH
	M

22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To be Completed by MEDICAL EXAMINER

23a. On the basis of examination and/or investigation in my opinion death occurred at the time, date and place and due to the cause(s) and manner as stated. (Signature and Title) MD/ME

23b. DATE SIGNED (Mo., Day, Yr)	23c. HOUR OF DEATH
December 23, 2004	4:52 A M

23d. MEDICAL EXAMINER'S CASE # 04-15-01325

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) [redacted], M.D., M.E. 3126 Oaks Club Road, West Palm Beach, FL 33406

25a. SUBREGISTRAR – SIGNATURE AND DATE	25b. LOCAL REGISTRAR – SIGNATURE	25c. DATE REGISTERED
	Donna Pethel	DEC 28 2004

Florida Brown December 28, 2004

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA ON THE FRONT, AND THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

FLORIDA DEPARTMENT OF HEALTH

DOH FORM 1946 (02-04)

B1262285

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED