FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Jul 14, 2002 8:00 am
Secretary of State
07-14-2002 90050 028 ***150.00

DOCUMENT # P95000061706

1. Entity Name
mid TOWN CONSTRUCTION Company INC

DO NOT WRITE IN THIS SPACE

B0128972

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	3. Mailing Address
2202 DuskIN Ave	P O Box 62
Suite, Apt. #, etc.	Suite, Apt. #, etc.
	Lake Worth
City & State: Orlando FL 32839	City & State: FL 33460
Zip / Country	Zip / Country

4. FEI Number: 59-333-7496 ☐ Applied For ☐ Not Applicable

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

DO NOT WRITE IN THIS SPACE

7. Name and Address of Current Registered Agent

Name: Peter Smith

Street Address (P.O. Box Number is Not Acceptable)

2202 Duskin Ave

City: Orlando **FL** Zip Code: 32839

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)

January 1 - May 1 Fee is $150.00
After May 1, Fee is $550.00
Amended UBR is $61.25
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

TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	Peter Smith PD 2202 DuskIN Ave Orlando FL 32839
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	Glasgow JC VP 2202 DuskIN Ave Orlando FL 32839
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	

DO NOT WRITE IN THIS SPACE

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 on an attachment with an address, with all other like empowered.

SIGNATURE: Peter Smith President 7/8/02
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034B (12/01)

2002 UNIFORM BUSINESS REPORT (UBR)

Attachment
B01a8977

DOCUMENT # P95000061706

1. Entity Name

MID TOWN CONSTRUCTION COMPANY, INC.

Principal Place of Business	Mailing Address
2202 DUSKIN AVE. ORLANDO FL 32839	P.O. BOX 62 LAKE WORTH FL 33460

[redacted]

DO NOT WRITE IN THIS SPACE

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

4. FEI Number 59-3337496 ☐ 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
SMITH, PETER 2202 DUSKIN AVENUE ORLANDO FL 32839	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

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 $550.00
After September 13, 2002 Fee will be $750.00
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	PD SMITH, PETER 2202 DUSKIN AVENUE ORLANDO FL 32839	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	V GLASGOW, J C 2202 DUSKIN AVE ORLANDO FL 32839	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	[redacted]	☐ 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

CR2E034 (4/02)

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 REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF OFFICER OR DIRECTOR

Attachment 5

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State

June 20, 2002

MID TOWN CONSTRUCTION COMPANY, INC.
P.O. BOX 62
LAKE WORTH, FL 33460

SUBJECT: MID TOWN CONSTRUCTION COMPANY, INC.
Ref Number: P95000061706

We have received your document for MID TOWN CONSTRUCTION COMPANY, INC. and check(s) totaling $150.00. However, your check(s) and document are being returned for the following:
Only applications approved by the Department of State are acceptable. Please complete the enclosed approved application and return it to our office.

TO AVOID THE $400.00 LATE FEE, PLEASE RETURN THE CORRECTED REPORT TO: DIVISION OF CORPORATIONS, P.O. BOX 1500, TALLAHASSEE, FLORIDA 32302-1500 WITHIN 30 DAYS OF THE DATE OF THIS LETTER.

If you have any questions concerning the filing of your document, please call (850) 245-6059.

Justin M Shivers
Document Specialist

Letter Number: 702A00040005

NOTIFICATION OF INITIAL TREATMENT

Attachment

Date: 5/29/02

FLORIDA DEPARTMENT OF LABOR & EMPLOYMENT SECURITY
DIVISION OF WORKER'S COMPENSATION

To: Melissa Cempella

B0128972 Fax No. 860-757-5979

From: Dr Matuszak

No. of Pages:

TREATING PHYSICIAN:
THIS FORM MUST BE COMPLETED AND RECEIVED BY THE CARRIER WITHIN THREE (3) DAYS OF INITIAL TREATMENT

Since this form must be received by the carrier within 3 days of initial treatment, it may be faxed to the carrier.

PLEASE PRINT OR TYPE

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	DATE OF ACCIDENT
Smith, Peter	095-32-1407	10/10/01
CARRIER'S NAME & ADDRESS	**EMPLOYERS NAME & ADDRESS**	
Hartford	Miracola Properties	

1. DATE OF FIRST TREATMENT: 5/29/02 2. IS ADDITIONAL TREATMENT NEEDED? ☒ YES ☐ NO

3. NEXT SCHEDULED APPOINTMENT: 6/26/02

4. DIAGNOSIS (Use ICD-9-CM Codes and narratives):
Primary:
Contusion clavicle (R) 923.00
Sprain (R) Ankle 845.02

5. IS THE PRIMARY DIAGNOSIS RELATED TO THIS ON-THE-JOB INJURY? ☒ YES ☐ NO

6. INITIAL PLAN OF TREATMENT
Mobic / P.T. 3x3
No lift/reach over 30 lbs
No ladder climbing prolonged standing or walking

7. CURRENT WORK STATUS: ☐ Unable to work ☐ Return to Work Full Duty ☒ Return to Work Modified Duty

IF NECESSARY, PLEASE ATTACH ANY ADDITIONAL INFORMATION

IT IS THE PROVIDER'S RESPONSIBILITY TO PROVIDE COPIES OF MEDICAL RECORDS TO APPROPRIATE PARTIES PURSUANT TO SECTION 440.13, FLORIDA STATUTES.

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

PROVIDER'S NAME, ADDRESS & TELEPHONE #: (561) 967-6500

Orthopedic Center 4801 So. Congress Ave., Lake Worth, FL 33461

- ☐ Edward W. Sandall, M.D.
- ☐ Michael S. Zelde, M.D.
- ☐ Marvin A. Kohn, M.D.
- ☐ Joseph B. Chalal, M.D.
- ☐ Emilio S. Musso, M.D.
- ☐ Jeffrey L. Kugler, M.D.
- ☐ Louis F. Donaghue, M.D.
- ☒ Charles J. Matuszak,M.D.
- ☐ Jeffrey A. Press, M.D.
- ☐ Theresa E. Rattey, M.D.
- ☐ Charles W. Graubert M.D.
- ☐ James T. Clancy, D.P.M.
- ☐ John S. Levin, D.P.M.

PROVIDER'S DBPR# ME0031593

DATE PREPARED: 5/29/02

FOR CARRIER USE

Adjuster Agrees with Initial Treatment Plan? ☐ YES ☐ NO

INITIAL TREATMENT PLAN AUTHORIZED? ☐ YES ☐ NO

IF NO, EXPLAIN _____

ADJUSTER SIGNATURE

DATE

ATTORNEYS JO ANN HOFFMAN, Moore, Baisden & Selwood, P.A.
PERSONAL INJURY • WORKERS' COMPENSATION • SOCIAL SECURITY

REPLY TO: 2247 Palm Beach Lakes Blvd., #223
West Palm Beach, Florida 33409

4403 West Tradewinds Avenue
Lauderdale-By-The-Sea, Florida 33308

JO ANN HOFFMAN
• Board Certified Workers' Compensation
VANCE B. MOORE
RANDELL BAISDEN
JASON T. SELWOOD
STUART A. NELSON
• Board Certified Civil Trial Law
MARIO L. PEREZ
MARIZELLE P. SALAZAR

Palm Beach: (561) 471-9954
Ft. Lauderdale (954) 772-2644
Boca Raton: (561) 393-6300
Miami: (305) 624-2255
Fax: (561) 471-9931

Attachment DHP95 0006 BD128972

May 10, 2002

Mr. Peter Smith
P.O. Box 62
Lake Worth, FL 33460

RE: D/Accident: 10/10/2001

Dear Mr. Smith:

An appointment has been set up for you with Dr. Charles Matuszak on Wednesday, May 29, 2002, at 1:00PM, at 4801 S. Congress Avenue, Lake Worth, FL 33461, 4th Floor. Dr. Matuszak's phone number is (561) 967-6500 should you need directions.

Please be sure to keep this appointment and bring any x-rays and medical reports you may have.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Marizelle P. Salazar

Marizelle Poblete Salazar, Esq.

MPS:neq

Attachment
DA#P95-DU0260706
B0128972

March 4, 2002

Nancy Lehmann, Esquire
224 Datura Street
Suite 412
West Palm Beach, FL 33401

Re: Peter Smith

Dear Ms. Lehmann:

This letter shall serve as formal notice that I no longer wish for your firm to represent my interest with reference to the above-captioned matter.

I would appreciate your forwarding the entire contents of my file to the law office of Attorneys Jo Ann Hoffman, Moore, Baisden & Selwood, P.A., 4403 W. Tradewinds Avenue, Lauderdale By The Sea, FL 33308. If you have any questions, kindly direct all correspondence to my new attorney, Marizelle Salazar, (561) 471-9954.

Your prompt and courteous attention to this matter will be greatly appreciated.

Very truly yours,

PETER SMITH
P.O. Box 62
Lake Worth, FL 33460

Good Samaritan
Medical Center

Attachment
DH P950000706

Emergency Department: 561-650-6309
B012897
Date: 10/12/2001 Time: 12/30/1899

You have a responsibility to monitor your condition and follow the care instructions provided. If you have concerns that your condition is not improving or is becoming worse, please immediately contact your physician or the follow-up physician or this Emergency Department.

Patient Name: SMITH, PETER	Doctor: Theresa Shaner P.A.

Patient Discharge Instructions: Document 377 Last Update: 12/08/2000

SPRAINED ANKLE:

You have a sprained ankle. When you twist your ankle, the ligaments that hold the joint together are injured. This often causes a lot of swelling and pain. Proper treatment will reduce your pain, shorten the period of disability, and help prevent re-injury. To treat this you should:

- Elevate your ankle for the next 2-4 days.
- Apply ice packs to the injury for 20-30 minutes every 2-3 hours.
- Keep the ankle wrapped in a compression bandage or splint as long it is painful or swollen.
- Do not walk on your ankle if it still hurts. This can slow healing. Use crutches if necessary until weight bearing is painless.
- Air, foam, or gel-lined braces can be used to protect the ankle from further injury until the joint is completely healed.

Ankle rehabilitation exercises may be needed to speed your recovery and make the joint more stable. Most moderate ankle sprains will heal completely in 6 weeks. However, if the sprain is severe, a cast or even surgery may be needed. Please see your doctor for follow-up as advised.

Special Instructions:

Please review your prescription with the pharmacist. You should receive instructions on appropriate precautions, potential side effects and proper use.

Prescriptions:

Vioxx Oral Tablet 25 Milligram 1 TABLET DAILY DISPENSE AMOUNT: 4 TABLET (four)

You have a responsibility to make an appointment and be evaluated by a follow-up physician. Please call immediately for this appointment. If required, please obtain approval from your HMO.

Referring Physician:	You should make an appointment:
Gary M Wexler, MD 3401 PGA Blvd #500 Palm Beach Gardens FL 33410 Phone:561-694-7776 Fax:561-694-0611	For 3 day(s) from today. (Monday, October 15, 2001)