

# 2004 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Aug 02, 2004 8:00 am**  
**Secretary of State**

08-02-2004 90005 034 \*\*\*158.75

**DOCUMENT # P95000081264**

1. Entity Name  
**MACKEY HEALTH INSTITUTE, INC.**



Principal Place of Business  
1900 S OLIVE AVE  
2ND FLOOR  
WEST PALM BEACH, FL 33401 US

Mailing Address  
1900 S OLIVE AVE  
2ND FLOOR  
WEST PALM BEACH, FL 33401 US

**\$4065967**



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

3. Mailing Address  
Suite, Apt. #, etc.  
City & State  
Zip Country

07212004 Chg-P CR2E034 (10/03)

4. FEI Number  
**59-3311353**

Applied For  
☐ Not Applicable

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

6. Name and Address of Current Registered Agent  
**MACKEY, BONNIE**  
**1900 S OLIVE AVE**  
**WEST PALM BEACH, FL 33401**

7. Name and Address of New Registered Agent  
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 \_\_\_\_\_ (NOTE: Registered Agent signature required when reinstating) DATE \_\_\_\_\_

**FILE NOW!!! FEE IS \$550.00 Due by September 8, 2004**

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<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | VP<br>EGOL, NANCY<br>1900 S OLIVE AVE<br>WEST PALM BEACH, FL 33401 <input type="checkbox"/> Delete            | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | S<br>Mackey, Nancy<br>1900 S Olive Avenue<br>West Palm Beach, FL 33401 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition  |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | S<br>CHEN, REGINA<br>1900 S OLIVE AVE<br>WEST PALM BEACH, FL 33401 <input checked="" type="checkbox"/> Delete | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | VP<br>Hunter, Carol<br>1900 S Olive Avenue<br>West Palm Beach, FL 33401 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | T<br>MACKEY, SUSAN<br>1900 S OLIVE AVE<br>WEST PALM BEACH, FL 33401 <input type="checkbox"/> Delete           | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition  |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition  |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> Addition  |
| TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP | <input type="checkbox"/> Delete   | TITLE<br>NAME<br>STREET ADDRESS<br>CITY-ST-ZIP        | <input type="checkbox"/> Change <input type="checkbox"/> 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: Bonnie Mackey July 27, 2004 561.832.1900

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #



Leaders in the Field of Integrative Medicine and HealthCare

Bonnie Mackey, MSN, ARNP, HNC, MTC  
President, Holistic Nurse Practitioner

Integrative HealthCare  
Practice Development • Education & Training

July 27, 2004

Division of Corporations  
Annual Report Business Report Section  
PO Box 6327  
Tallahassee, FL 32314-6198

RE: Mackey Health Institute, Inc.  
Document # P 95000081264  
FEI #: 59-3311353

To Whom It May Concern:

I am enclosing the completed For Profit Corporation Annual Report for the Mackey Health Institute, Inc. I am requesting a waiver of the late fee due to not having received the annual report notice. I have enclosed a check #3212 in the amount of \$158.75 to cover the cost of the filing fee and the certificate of status.

If you need additional information please do not hesitate to contact me. I appreciate your time and consideration in this matter.

Sincerely,

  
Bonnie Mackey, MSN, ARNP, HNC