

AND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER SEPTEMBER 15, 1999.
MOUNT DUE ON OR BEFORE 09/15/99: \$550 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$750).

PROFIT
CORPORATION
ANNUAL REPORT
1999



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
Sep 14, 1999 8:00 am
Secretary of State

09-14-1999 90002 029 ***150.00

DOCUMENT # **P95000083694**

Corporation Name

AST MEDICAL SUPPLY AND EQUIPMENT INC.

Principal Place of Business

717 PONCE DE LEON BLVD
SUITE 239
CORLA GABLES FL 33134

Mailing Address

717 PONCE DE LEON BLVD
SUITE 239
CORLA GABLES FL 33134



DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified

10/30/1995

4. FEI Number

65-0621247

Applied For

Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution ☐

\$5.00 May Be
Added to Fees

8. This corporation owes the current year
Intangible Personal Property. ☐ Yes ☐ No

Principal Place of Business

2a. Mailing Address

26

Suite, Apt. #, etc.

Suite, Apt. #, etc.

27

City & State

City & State

28

Zip

Country

Zip

Country

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

VALDES, REINA L
717 PONCE DE LEON BLVD
SUITE 239
CORLA GABLES FL 33134

81 Name

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

83

84 City

FL

85 Zip Code

Pursuant to the provisions of sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, section 607.0505, Florida Statutes.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

NAME	DELETE	1.1 TITLE	Change	Addition
PSTD VALDES, REINA L 717 PONCE DE LEON BLVD #239 CORLA GABLES FL 33134	<input type="checkbox"/>	1.2 NAME	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	1.3 STREET ADDRESS	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	1.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	2.1 TITLE	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	2.2 NAME	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	2.3 STREET ADDRESS	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	2.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	3.1 TITLE	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	3.2 NAME	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	3.3 STREET ADDRESS	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	3.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	4.1 TITLE	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	4.2 NAME	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	4.3 STREET ADDRESS	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	4.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	5.1 TITLE	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	5.2 NAME	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	5.3 STREET ADDRESS	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	5.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	6.1 TITLE	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	6.2 NAME	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	6.3 STREET ADDRESS	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	6.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>

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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE:

SIGNATURE REQUIRED

9/5/99

CR2E034 (5/99)

P45 000083644
614880

FAST MED. SUPPLY.

9/5/99

(FBI NUMBER 65-0621247)
717 PONCE DE LEON #239
CORAL GABLES FL 33134
TO: DEP. OF STATE.

I RECEIVED THIS DOCUMENT
THAT SAY TO PAY \$550.00 AS
A PENALTY. BUT I SEND THE
PRIOR AMOUNT ON MARCH 8/99
CHECK #163 ON TIME.

SO PLEASE CHECK YOUR RECORD
BECAUSE ACCORDING TO MY RECORD THIS
CHECK WAS NEVER CASHING.

SINCERLY

REINA L. VALDES
