

**2000 UNIFORM BUSINESS REPORT (UBR)****DOCUMENT # P96000007347**

1. Entity Name

**HEALTH IMPROVEMENT MASSAGE THERAPY CLINIC, INC.****FILED**  
**Mar 08, 2000 8:00 am**  
**Secretary of State**

03-08-2000 90023 021 \*\*\*150.00

Principal Place of Business

Mailing Address

1730 ALT. 19 S., STE. G-300  
TARPON SPRINGS FL 346891730 ALT. 19 S., STE. G-300  
TARPON SPRINGS FL 34689-1984

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City &amp; State

City &amp; State

Zip

Country

Zip

Country

4. FEI Number

59-3363961

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

**PAPAGEORGIOU, SOKRATIS J**  
**1730 ALT. 19 S., STE. G-300**  
**TARPON SPRINGS FL 34689**

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, 2000 Fee will be \$550.00**  
**Make Check Payable to Department of State**10. Election Campaign Financing  
Contribution ☐**\$5.00** May Be  
Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS

TITLE **P** ☐ Delete  
NAME **PAPAGEORGIOU, SOKRATIS J.**  
STREET ADDRESS **1730 ALT. 19 S., SUITE G-300**  
CITY-ST-ZIP **TARPON SPRINGS FL**TITLE ☐ Change ☐ Addition  
NAME  
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CITY-ST-ZIPTITLE ☐ Delete  
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STREET ADDRESS  
CITY-ST-ZIP

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

3-3-00 (727) 943-4363

CR2E034 (9/99)