

# 2001 UNIFORM BUSINESS REPORT (UBR)

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DOCUMENT # P96000089683

1. Entity Name

ALLCARE ORTHO-PROSTHETIC CENTER II, INC.

Principal Place of Business

3750 WEST 16 AVE. #404  
HIALEAH FL 33012

Mailing Address

3750 WEST 16 AVE. #404  
HIALEAH FL 33012

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

65-0706408

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

MIRANDA, FRANCISCA  
3750 WEST 16TH AVENUE  
#404  
HIALEAH FL 33012

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 \$550.00**  
**After September 12, 2001 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 DTV  
NAME MIRANDA, FRANCISCA  
STREET ADDRESS 3750 W. 16TH AVENUE, #404  
CITY-ST-ZIP HIALEAH FL 33012 ☐ Delete

TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Delete  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Change ☐ Addition  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ Delete  
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TITLE ☐ Change ☐ Addition  
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TITLE ☐ Change ☐ Addition  
NAME  
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:

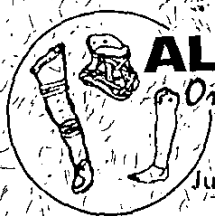
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

07-08-01 305-362-6000

CR2E034 (5/01)



**ALL CARE**  
Ortho-Prosthetic Center II

July 3, 2001

3750 W. 16th Avenue, Suite 404  
Hialeah, Florida 33012

Phone: (305) 362-6000  
Fax: (305) 362-6672

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Gentlemen:

Attached will find signed Uniform business report for 2001 and also copy of front and back of check in the amount of \$150.00 paid by our bank to you in April 2001.

We never received from you this form mention above in order to sign.

Please correct your records.

Your cooperation in resolving this matter will be greatly appreciated.

Francisca Miranda