

2001 UNIFORM BUSINESS REPORT (UBR)**FILED**
May 18, 2001 8:00 am
Secretary of State

05-18-2001 90021 013 ***150.00

0420737

DOCUMENT # P97000072718

1. Entity Name

MUSCULAR THERAPY & REHAB CENTER, INC.

Principal Place of Business

**5386 SPRINGS HILL DR
SPERINGS HILL FL 34606**

Mailing Address

**5386 SPRINGS HILL DR
SPERINGS HILL FL 34606**

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 **59-3465485**

Applied For

Not Applicable

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

6. Name and Address of Current Registered Agent

**STOECKICHT, LOUIS M
18196 WINDING OAKS BLVD
HUDSON FL 34667**

7. Name and Address of New Registered Agent

Name

Lisa Arrington

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

5386 Spring Hill Drive

City

Spring Hill

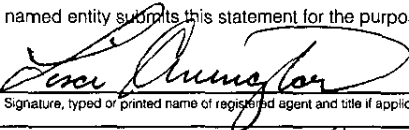
FL

Zip Code

34606

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

**3/6/01**

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, 2001 Fee will be \$550.00
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

TITLE	DV	<input type="checkbox"/> Delete
NAME	ARRINGTON, LISA M	
STREET ADDRESS	1213 LODGE CIR	
CITY-ST-ZIP	SPRING HILL FL 34606	
TITLE	DVS	<input checked="" type="checkbox"/> Delete
NAME	STOECKICHT, LYNNE	
STREET ADDRESS	18196 WINDING OAKS BLVD	
CITY-ST-ZIP	HUDSON FL 34667	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	DPVTS	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Change <input type="checkbox"/> 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 #

CR2E034 (10/00)