

**NOT-FOR-PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**

FILED
Mar 26, 2002 8:00 am
Secretary of State

03-26-2002 90013 003 ***150.00

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1. Entity Name,
Gold Coast Health Care Cent

1345 SW 87 Avenue
Miami FL 33174

B0050549

2. Principal Place of Business		3. Mailing Address		4. FEI Number		Applied For	
Suite, Apt. #, etc.		Suite, Apt. #, etc.				Not Applicable	
City & State		City & State					
Zip	Country	Zip	Country	5. Certificate of Status Desired ☐		\$8.75 Additional Fee Required	

DO NOT WRITE IN THIS SPACE

7. Name and Address of Current Registered Agent	
Name Fabiana Garcia	
Street Address (P.O. Box Number is Not Acceptable) 1345 SW 87 Avenue	
City Miami FL	Zip Code 33174

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 _____ DATE _____
Signature, type or printed name of registered agent and date if applicable. (NOTE: Registered Agent signature required when transferring)

9. Election Campaign Financing
Trust Fund Contribution. ☐ **\$5.00 May Be Added to Fees**

10. OFFICERS AND DIRECTORS			
TITLE	Fabiana Garcia	TITLE	
NAME	1345 SW 87 Ave	NAME	
STREET ADDRESS	Miami FL 33174	STREET ADDRESS	
CITY-STATE-ZIP		CITY-STATE-ZIP	
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-STATE-ZIP		CITY-STATE-ZIP	
TITLE	No changes	TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-STATE-ZIP		CITY-STATE-ZIP	
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-STATE-ZIP		CITY-STATE-ZIP	
TITLE		TITLE	
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-STATE-ZIP		CITY-STATE-ZIP	

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(5)(b), 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 617, Florida Statutes; and that my name appears in Block 10 or on an attachment with an address, with all other like empowered.

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Deputy State #

CIR2E037B (12/01)