

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P98000022936

1. Entity Name

BEST CARE RESPIRATORY & MEDICAL SUPPLY, INC.

FILED
May 08, 2000 8:00 am
Secretary of State

05-08-2000 90140 013 ***150.00

Principal Place of Business

Mailing Address

3380 SE LAKE WEIR AVE
SUITE 'E'
OCALA FL 34471

399 S.E. 90TH STREET
OCALA FL 34480-5770

2. Principal Place of Business

3. Mailing Address

399 SE 90 ST

Suite, Apt. #, etc.

City & State

City & State

OCALA, FL

Zip

Country

Zip

Country

34480

U.S.A.

4. FEI Number

59-3502844

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

HOWARD, DAVID E
399 S.E. 90TH STREET
OCALA FL 34480

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

4-27-00

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
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
D
HOWARD, DAVID E
399 S.E. 90TH STREET
OCALA FL 34480 ☐ Delete

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

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP
D
HOWARD, DEBBIE E
399 S.E. 90TH STREET
OCALA FL 34480 ☐ Delete

TITLE
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CITY-ST-ZIP
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☐ Change ☐ Addition

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

4-27-00

Date

Daytime Phone #

CR2E034 (9/99)