


**2004 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Feb 18, 2004 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # P98000052631</b> 1. Entity Name OCCUMED OCCUPATIONAL MEDICINE SPECIALISTS, INC.	
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02122004 No Chg-P CR2E034 (10/03)

Principal Place of Business 10 NW LEJEUNE RD 501 MIAMI, FL 33126	Mailing Address 10 NW LEJEUNE RD 501 MIAMI, FL 33126
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**DO NOT WRITE IN THIS SPACE**

4. FEI Number 65-0842202	Applied For Not Applicable
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5. Certificate of Status Desired ☐ **\$8.75** Additional  
Fee Required

**6. Name and Address of Current Registered Agent**

OCAMPO, ALVARO MD  
5961 SW 81 STREET  
MIAMI, FL 33143

**DO NOT WRITE  
IN THIS SPACE**

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE \_\_\_\_\_

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE \_\_\_\_\_

**FILE NOW!!! FEE IS \$150.00**  
**After May 1, 2004 Fee will be \$550.00**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

**\$5.00** May Be  
Added to Fees

U00000055815  
02/18/04-80019-015 150.00

**10. OFFICERS AND DIRECTORS**

TITLE NAME STREET ADDRESS CITY - ST - ZIP	P OCAMPO, ALVARO J 5961 SW 81 STREET MIAMI, FL 33143
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**DO NOT WRITE  
IN THIS SPACE**

12. 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 10 or Block 11 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 #

ALVARO OCAMPO MD 305 7744644

2-12-4