

**FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**

FILED
May 05, 2003 8:00 am
Secretary of State

05-05-2003 91760 045 ***150.00

DOCUMENT #	P98000081944
1. Entity Name	ALL FAMILY WORKMAN MEDICAL CENTERS, INC.

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business 995 ROCK ISLAND ROAD Suite, Apt. #, etc.		3. Mailing Address 995 ROCK ISLAND ROAD Suite, Apt. #, etc.	
City & State N. LAUDERDALE, FL		City & State N LAUDERDALE.	
Zip 33068-2313	Country BROWARD	Zip 33068-2313	Country BROWARD

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4. FEI Number 65-0862186		Applied For <input checked="" type="checkbox"/> Not Applicable	
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required	

**DO NOT WRITE
IN THIS SPACE**

7. Name and Address of Current Registered Agent

Name ELOI EMMANUEL	
Street Address (P.O. Box Number is Not Acceptable) 995 ROCK ISLAND RD	
City N LAUDERDALE	Zip Code 33068

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  **ELOI EMMANUEL** **4/28/03**
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

January 1 - May 1 Fee is \$150.00 After May 1, Fee is \$550.00 Amended UBR is \$61.25 Make Check Payable to Florida Department of State	9. Election Campaign Financing <input type="checkbox"/> \$5.00 May Be Added to Fees Trust Fund Contribution.
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10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	ELOI EMMANUEL 995 ROCK ISLAND RD N LAUDERDALE FL 33068
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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 on an attachment with an address, with all other like empowered.

SIGNATURE:  **4/28/03**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #