

# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Feb 08, 2000 8:00 am**  
**Secretary of State**

02-08-2000 90132 032 \*\*\*158.75

**DOCUMENT # P98000096446**

1. Entity Name

**BEACHSIDE CHIROPRACTIC LIFE CLINIC, P.A.**

Principal Place of Business

**839 BARTON BLVD.  
 ROCKLEDGE FL 32955**

Mailing Address

**839 BARTON BLVD.  
 ROCKLEDGE FL 32955-3127**

00016019

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number **59-3544003**

Applied For  
 Not Applied

Zip

Country

Zip

Country

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

**FOGARTY, KEVIN G D.C.  
 839 BARTON BLVD.  
 ROCKLEDGE FL 32955**

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

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 Added to Fee

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE ☐ Delete  
 NAME **D**  
 STREET ADDRESS **FOGARTY, KEVIN G D.C.**  
 CITY-ST-ZIP **839 BARTON BLVD.  
 ROCKLEDGE FL 32955**

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

TITLE ☐ Delete  
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 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, 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 #

**1/30/00**

**321 6360**