

2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 11, 2002 8:00 am
Secretary of State

02-11-2002 90135 036 ***158.75

0123618 AV

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**



DO NOT WRITE IN THIS SPACE

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 Applicable

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, 2002 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 ☐ Delete
 NAME **D**
 STREET ADDRESS **FOGARTY, KEVIN G D.C.**
 CITY-ST-ZIP **839 BARTON BLVD.
 ROCKLEDGE FL 32955**

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

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Change ☐ Addition
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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 if changed, or on an attachment with an address with all duties like empowered.

SIGNATURE:

SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Dr. Kevin Fogarty

Date

1-21-02

321-636-5200

Daytime Phone #

CR2E034 (9/01)