

2001 UNIFORM BUSINESS REPORT (UBR)

4/1

FILED
Jul 18, 2001 8:00 am
Secretary of State

04-18-2001 90060 001 ***476.25

DOCUMENT # P99000000359

1. Entity Name

PHYSICAL THERAPY TREATMENT, INC.

Principal Place of Business

13857 LONG LAKE LANE
 PORT CHARLOTTE FL 33953

Mailing Address

13857 LONG LAKE LANE
 PORT CHARLOTTE FL 33953

2. Principal Place of Business

Suite, Apt. #, etc.

City & State

Zip

Country

3. Mailing Address

Suite, Apt. #, etc.

City & State

Zip

Country

4. FEI Number

APPLIED FOR

Applied For

Not Applicable

5. Certificate of Status Desired

☒

\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

FOENG, GERARD A CHIN
 13857 LONG LAKE LN
 PORT CHARLOTTE FL 33953

7. Name and Address of New Registered Agent

Name

GERARD J.M. CHIN-A-FOENG

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, 2001 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

TITLE ☐ Delete
 NAME **GERARD J.M. CHIN-A-FOENG**
 STREET ADDRESS **13857 LONG LAKE LANE**
 CITY-ST-ZIP **PORT CHARLOTTE FL 33953**

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

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 NAME
 STREET ADDRESS
 CITY-ST-ZIP

TITLE ☐ Delete
 NAME
 STREET ADDRESS
 CITY-ST-ZIP

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

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

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

TITLE ☐ Change ☐ Addition
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 NAME
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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 other like empowered.

SIGNATURE

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

GERARD J.M. CHIN-A-FOENG

Date

3/26/01

Daytime Phone #

941-764-6242

CR2E034 (10/00)

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, certain individuals, and others. See instructions.)

► Keep a copy for your records.

EIN

OMB No. 1545-0003

Attachment
#P99000000359

Please type or print clearly.	1 Name of applicant (legal name) (see instructions) PHYSICAL THERAPY TREATMENT, INC.	
	2 Trade name of business (if different from name on line 1)	3 Executor, trustee, "care of" name
	4a Mailing address (street address) (room, apt., or suite no.) 13857 LONG LAKE LANE	5a Business address (if different from address on lines 4a and 4b)
	4b City, state, and ZIP code PORT CHARLOTTE, FLORIDA 33953	5b City, state, and ZIP code
	6 County and state where principal business is located CHARLOTTE, FLORIDA	
	7 Name of principal officer, general partner, grantor, owner, or trustor—SSN or ITIN may be required (see instructions) ► <i>40-86-1677</i> GERARD J. M. CHIN-A-FOENG	

8a Type of entity (Check only one box.) (see instructions)

Caution: If applicant is a limited liability company, see the instructions for line 8a.

<input type="checkbox"/> Sole proprietor (SSN)	<input type="checkbox"/> Estate (SSN of decedent)
<input type="checkbox"/> Partnership	<input type="checkbox"/> Plan administrator (SSN)
<input type="checkbox"/> REMIC	<input type="checkbox"/> Other corporation (specify) ►
<input type="checkbox"/> State/local government	<input type="checkbox"/> Trust
<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> Federal government/military
<input type="checkbox"/> Other nonprofit organization (specify) ►	(enter GEN if applicable)
<input type="checkbox"/> Other (specify) ►	

8b If a corporation, name the state or foreign country (if applicable) where incorporated	State FLORIDA	Foreign country
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9 Reason for applying (Check only one box.) (see instructions)	<input type="checkbox"/> Banking purpose (specify purpose) ►
<input checked="" type="checkbox"/> Started new business (specify type) ► PHYSICAL THERAPY	<input type="checkbox"/> Changed type of organization (specify new type) ►
<input type="checkbox"/> Hired employees (Check the box and see line 12.)	<input type="checkbox"/> Purchased going business
<input type="checkbox"/> Created a pension plan (specify type) ►	<input type="checkbox"/> Created a trust (specify type) ►
	<input type="checkbox"/> Other (specify) ►

10 Date business started or acquired (month, day, year) (see instructions) JANUARY 4, 1999	11 Closing month of accounting year (see instructions) 12
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12 First date wages or annuities were paid or will be paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien. (month, day, year)	TBA
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13 Highest number of employees expected in the next 12 months. Note: If the applicant does not expect to have any employees during the period, enter -0-. (see instructions)	Nonagricultural 0	Agricultural	Household
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14 Principal activity (see instructions) ►	PHYSICAL THERAPY SOFTWARE
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15 Is the principal business activity manufacturing? If "Yes," principal product and raw material used ►	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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16 To whom are most of the products or services sold? Please check one box. <input type="checkbox"/> Public (retail) <input type="checkbox"/> Other (specify) ►	<input type="checkbox"/> Business (wholesale) <input checked="" type="checkbox"/> N/A
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17a Has the applicant ever applied for an employer identification number for this or any other business? Note: If "Yes," please complete lines 17b and 17c.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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17b If you checked "Yes" on line 17a, give applicant's legal name and trade name shown on prior application, if different from line 1 or 2 above. Legal name ► STAR SPORTS TRAINING AND REHAB Trade name ► SAME
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17c Approximate date when and city and state where the application was filed. Enter previous employer identification number if known. Approximate date when filed (mo., day, year) City and state where filed DEC 23, 1992 PORT CHARLOTTE, FL	Previous EIN 65 0383841
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Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.	Business telephone number (include area code) 941-764 6242
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Name and title (Please type or print clearly.) ►	GERARD J. M. CHIN-A-FOENG, PRESIDENT	Fax telephone number (include area code) 941-764-6107
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Signature ►	<i>[Signature]</i>	Date ►	7/10/01
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Note: Do not write below this line. For official use only.

Please leave blank ►	Geo.	Ind.	Class	Size	Reason for applying
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