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**FILED**  
**Apr 18, 2000 8:00 am**  
**Secretary of State**

01-18-2000 90181 013 \*\*\*150.00

**DOCUMENT # P99000026402**

1. Entity Name

**HABANA HOSPITAL PHARMACY WHOLESALE, INC.**

Principal Place of Business

4710 NORTH HABANA AVENUE #101  
TAMPA FL 33614

Mailing Address

4710 NORTH HABANA AVENUE #101  
TAMPA FL 33614-7143

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City &amp; State

City &amp; State

Zip

Country

Zip

Country

4. FEI Number

59-3566571

Applied For  
Not Applicable5. Certificate of Status Desired ☐\$8.75 Additional  
Fee Required

6. Name and Address of Current Registered Agent

**DYKES, WALTER E**  
**4710 NORTH HABANA AVENUE #101**  
**TAMPA FL 33614**

7. Name and Address of New Registered Agent

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 Be  
 Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	NAME	STREET ADDRESS	CITY-ST-ZIP	<input type="checkbox"/> Delete
PD	DYKES, WALTER E	11212 CARROLLWOOD DRIVE	TAMPA FL 33618	<input type="checkbox"/>
ST	DYKES, ANN P	11212 CARROLLWOOD DRIVE	TAMPA FL 33618	<input type="checkbox"/>
V	W. EDMUND DYKES	10701 LAKE CARROLL WAY	TAMPA FL 33618	<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

TITLE	NAME	STREET ADDRESS	CITY-ST-ZIP	<input type="checkbox"/> Change	<input type="checkbox"/> Add
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

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

Date

Daytime Phone

1-7-2000 (813) 892-7771