

2000 UNIFORM BUSINESS REPORT (UBR)

06-14-2000 90039 023 ***150.00

10f2

DOCUMENT # P99000037358

1. Entity Name

COMFORT CARE MEDICAL REHABILITATION CENTER, INC.

FILED

00 JUL 24 AM 8:54

SECRETARY OF STATE
TALLAHASSEE FLORIDA
00064357

Principal Place of Business

Mailing Address

ENCLAVE
NORTH HABANA AVENUE, SUITE 201
FL 33614

THE ENCLAVE
4728 NORTH HABANA AVENUE, SUITE 201
TAMPA FL 33614-7100

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number

59-3554452

Applied For

Not Applicable

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

Name

Street Address (P.O. Box Number is Not Acceptable)

City

FL

Zip Code

TINDALL, NATHANIEL W II
205 WEST DR. MARTIN L KING, JR. BLVD.
SUITE 103
TAMPA FL 33603

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 restate)

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	PCEO WITSELL-BROOKINS, SANDRA D 4728 NORTH HABANA AVE, SUITE 201 TAMPA FL 33614	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

CR2E034 (9/1/9)

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

SANDRA W. BROOKINS

Date

Daytime Phone #

4/10/00 (813) 876-0086

comfort care medical rehab center

Injury Recovery
Motor Vehicle • Slip and Falls

July 20, 2000

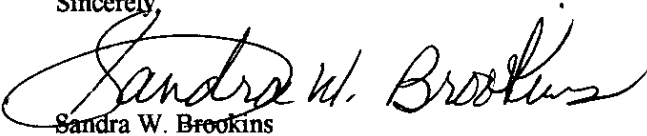
Florida Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Reference Number : P 99000037358

We are requesting that the late fee of \$400.00 be dismissed. We filed this form on April 10, 2000 and our check also dated for the same date has been cashed as well. (check # 2290)

Thank you for your attention to this matter.

Sincerely,


Sandra W. Brookins