

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P99000076335

1. Entity Name

ORTHOPAEDICS FORTE, INC.

FILED
Mar 03, 2000 8:00 am
Secretary of State

03-03-2000 90008 046 ***158.75

Principal Place of Business

722 VIA BIANCA DR.
DAVENPORT FL 33837

Mailing Address

722 VIA BIANCA DR.
DAVENPORT FL 33837-6559

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

59-3601353

Applied For

Not Applicable

5. Certificate of Status Desired

X

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

WELLS, JOHN M.
722 VIA BIANCA DR.
DAVENPORT FL 33837

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 | D | <input type="checkbox"/> Delete |
| NAME | WELLS, JOHN M | |
| STREET ADDRESS | 722 VIA BIANCA DR. | |
| CITY-ST-ZIP | DAVENPORT FL 33837 | |
| TITLE | | <input type="checkbox"/> Delete |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |
| TITLE | | <input type="checkbox"/> Delete |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |
| TITLE | | <input type="checkbox"/> Delete |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |
| TITLE | | <input type="checkbox"/> Delete |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |

| | | |
|----------------|---------------------|--|
| TITLE | D, P | <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | Wells, John M. | |
| STREET ADDRESS | 722 Via Bianca Dr. | |
| CITY-ST-ZIP | Davenport, FL 33837 | |
| TITLE | S, T, VP | <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition |
| NAME | Wells, Susan Lynn | |
| STREET ADDRESS | 722 Via Bianca Dr. | |
| CITY-ST-ZIP | Davenport, FL 33837 | |
| TITLE | | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |
| TITLE | | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |
| TITLE | | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
| NAME | | |
| STREET ADDRESS | | |
| 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 life empowered.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/19/00

Date

407-925-5835

Daytime Phone #

CR2E034 (9/99)